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Chief Review Services

REVIEW OF CF MEDICAL SERVICES – EXECUTIVE SUMMARY AND ACTION PLAN RESULTING FROM THE CDS TASK FORCE

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Team Leader: Harry Hubley, Principal
Deputy Team Leader: Norm Black, Principal
Team Member: Marie Kenny, Analyst
Team Leader of the November 1999 CDS Sponsored Task Force: Colonel Lise Mathieu, EA/CDS

Canada

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EXECUTIVE SUMMARY TO THE CRS REVIEW OF MEDICAL SERVICES

Background

1. In January 1999, at the request of the CDS, the Chief Review Services undertook a review of the provision of in-garrison medical services in the CF. The team was specifically tasked to examine the issues of *Continuity of Care* and the *Administration of Temporary Medical Categories*, as well as to examine other issues relating to the provision of care to CF members. The scope of this review has been restricted to in-garrison medical care delivered to Regular Force CF members and did not address medical matters relating to the Reserve Force, delivery of medical care in operations, or the delivery of dental services in the CF.

2. The Canadian Forces Medical Service (CFMS) has been on a journey of renewal and reengineering which began in 1990 when deficiencies in the operational deployability of its medical service were identified. Ten years later the CFMS can be characterized as a change-fatigued organization which has taken significant steps towards improving its operational focus while coping with downsizing, budget reductions and striving to maintain a high level of in-garrison care. The Op Phoenix reengineering exercise that began in 1994/95 was the principal architect of the restructured CFMS and provided the blue print to bring a greater operational focus to the medical services.

3. A basic premise of the Op Phoenix concept was to place greater reliance on the public sector health care systems to secure in-garrison medical care. However, concurrent with the downsizing and reengineering activity that was taking place in the CF, the civilian health care system was also experiencing a similar restructuring process. As a result, the CF was faced with the requirement to obtain many of its services from a system that was experiencing challenges of its own and under public scrutiny for the way it is delivering health care services.

Major Findings

4. Overarching Issues Impacting the Delivery of In-garrison Medical Care. There are two significant overarching issues impacting the delivery of in-garrison medical care. It was noted early in the review that significant regional differences exist across the country and hence, rather than taking a 'one size fits all' approach to addressing the in-garrison needs of CF members, corporate strategies need to be interpreted and tailored to meet local circumstances. As well, issues related to delivery of in-garrison medical services identified in the CFMS are closely interrelated and improvements in one functional area will have a ripple effect and alleviate other problems. Similarily, problems that are not attended to will worsen and possibly contribute to other problems.

5. Strategic Direction. The CFMS is currently operating without strategic direction. An impact of operating without that direction is high levels of staff frustration. As staffs are working hard for the organization, they are questioning how their efforts fit within an overall strategy for the Branch and how they can contribute to the accomplishment of goals that they are not aware of. As well, units in the field are looking for broad guidance to assist them in better managing their respective medical facilities.

6. Concept of Operations. While there is well-founded logic supporting the concept of operations for the CFMS, it is not yet working effectively for a range of reasons discussed throughout the report. Two of those reasons include a complex command and control structure without having internal mechanisms to ensure that it functions well, and the fact that the primary means of delivering in-garrison services was changed without ensuring that adequate mechanisms were in place to provide for the continuity of a comprehensive health care delivery system.

7. Standard of Care. Although excluded from provincial health care insurance plans, the Canada Health Act (1984) mandates that members of the CF receive the same level of health care services as all Canadians. Due to the reliance on the civilian health care sector for medical treatments and services that cannot be provided by in-garrison facilities, CF members receive a portion of their health care in the same manner as members of the public. Similarly, provincial licensure requirements for CF medical officers and extensive use of civilian physicians on contract to the CFMS ensure that professional standards are consistent with the public sector. The CFMS Spectrum of Health Care Document provides CF members with a range of medical services which are more comprehensive than the publicly funded provincial systems, while also providing for the unique aspects of CF occupational medicine along with other services such as over-the-counter medicines, therapy services etc. However, significant patient concerns exist in the areas of timeliness and access to medical services, regional inconsistencies in levels of service and the manner in which in-garrison care is being delivered as a result of a focus on operational responsibilities. CF members have expressed particular frustration with poor administration relating to the delivery of their in-garrison medical care.

8. Continuity of Care. Continuity of care is a significant concern of the CF leadership and CF members. The review team saw significant evidence to indicate that where continuity of care has been weak, patient care has been negatively impacted. The CF is pursuing strategies similar to their allied counterparts in attempting to strengthen continuity of care through increased civilianization. Evidence indicates that leadership must assume a more prominent role in this aspect of medical care than it has in the past.

9. Administration of Temporary Medical Categories. The concepts on which temporary medical categories (TMC)s are premised are sound. When they are injured, CF members need to have an opportunity to heal and not risk further injury to themselves or endanger other members of their units. When members are assigned TMCs they are not consistently well-attended to administratively and at times they are ostracized by their units. Leaders need to play an active role to ensure that members on TMCs are not

mismanaged or inappropriately administered within the system. While judgement is required in each individual case timely attention to matters related to TMCs is required in order that the needs of the patient and the CF are appropriately provided for.

10. CFMS Organizational and Command and Control Issues. This is a very complex area for the CFMS. The rationale to change from pre-Op Phoenix organization structures is sound as these earlier organizations that were structured to deliver in-garrison care proved not to work well when medical personnel were required for deployment. The structure that is in place today is responding to the requirement to fulfill operational needs, but is awkward, at times difficult to manage and not consistently supportive of the effective delivery of in-garrison medical care. Standing up the capability to secure contract physicians through the Designated Provider Plan and putting in place service level agreements between CF medical facilities and operational units, should ameliorate some of the difficulties being experienced. In order to carry out the mandate assigned to the CFMS through the Op Phoenix review, the existing command and control structure remains the most practical one at this time. However, consideration should be given in 18 to 24 months to establishing a centralized health services organization for the long term benefit of delivery of in-garrison care to CF members.

11. CFMS Resources, Establishment and Staffing. Making informed, objective judgements on the adequacy of the resourcing of the CFMS is difficult because of the current and prolonged high tempo of operations, unavailability of workload statistics since the discontinuance of that data gathering capability, significant numbers of unfilled billets and lack of an effective system for backfilling medical officers with civilian replacements. There is a preponderance of medical personnel with clinician skills performing management and administrative roles in the CFMS. At a time when certain clinician trades are operating short of establishment (medical officers and medical assistants) the resourcing question is broader than one of sufficiency, but extends to how appropriately and effectively the resources available are being applied.

12. Recruitment and Retention of Medical Officers. Staffing of medical officer positions is approaching critical levels (70 per cent vacancy forecasted by FY 2001) as recruitment of new general duty medical officers (GDMO)s into the Medical Officer Training Program (MOTP) is decreasing while the rate of attrition is rising (approaching 80 per cent attrition at the end of the obligatory period of service). The combination of these two trends is creating critical shortages of practicing MO clinicians. While the CFMS is pursuing strategies to increase recruitment, the effectiveness of which remain to be seen, little has been done to actively retain MOs. Recommendations in this report strive to address this problem.

13. Morale, Attitude and Capacity for Change. Morale in the CFMS is generally low. A significant factor contributing to low levels of morale is a widespread sentiment that the medical service is in a downward spiral, which is felt by clinicians and administrators alike and fed back to CFMS personnel during patient contacts. Attrition is high, particularly among MOs. Negative feedback reported in the media, government reports, and Standing Committee on National Defence and Veterans Affairs

(SCONDVA) hearings has further contributed to a decrease in morale amongst CFMS staff. Highly stressed professionals and support staff, wondering about the organization's strategic direction, fatigued by seemingly endless process changes and heavy workloads with little end in sight, are showing the strain through their attitude towards their work and patient care. While this group is left with little reserve capacity for change, further change is required. It will only be through significant assistance and support from the Branch, departmental leadership, and other sources that this group will be able to carry on to accomplish what remains to be done to address current deficiencies in the delivery of in-garrison care.

14. Administration of In-garrison Patient Care. CF patients closely associate the administration related to their care to the actual quality of care they are receiving. In many cases patients felt that they had been let down by the system's inability to staff in-garrison facilities with civilian doctors (continuity of care), physicians consumed with paper work during appointments rather than delivering care, patient records getting lost, incomplete files, lab test results going astray, and patient files not arriving in time for specialist consultations. Also, members attending civilian clinics when military medical facilities are not available are having to deal with administrative problems such as civilian clinics demanding cash payments for services rendered to CF patients. While some of these problems are being addressed by the CFMS, the review team offers recommendations and strategies to address others. Solutions being developed by the CFMS do not assure immediate fixes. Accordingly, in the interim, the patient continues to experience frustration and inconvenience with a consequent loss of trust and confidence in their medical system.

15. Migration of Ideas. The CFMS is comprised of a series of organizational and occupational stovepipes. These stovepipes interfere with the migration of ideas. The CFMS needs to take specific steps and actions in order to cross these boundaries and make sure good ideas and experiences with ideas that haven't worked so well, are shared within and across organizations. With high staff turnover, unfilled established positions and lack of depth in organizations due to staff reductions, there is no longer the opportunity for all CFMS personnel to learn by trial and error on their own. The regular sharing of ideas is critical to the future effectiveness of the CFMS. The sharing of ideas, knowledge, experiences and solutions to health care issues is critical within such a small cadre of health care professionals to ensure the ongoing effectiveness of the CFMS. It will be the responsibility of the leadership and senior management of the medical service to facilitate and encourage forums for the migration of ideas across the Branch.

16. Information Management and Information Technology. The CFMS does not yet have a centrally driven IM/IT system to support the delivery of in-garrison care. Similar systems are still in their infancy in the civilian sector with none known to be fully functional at this time. The CF has security implications to consider as it moves increasingly towards interfacing with the civilian sector. The *Migration of Ideas* concept offers the opportunity for sharing of interim IM/IT solutions that have been developed at the local level to bridge the gap between the present situation and the time that a corporate level CF IM/IT system is put in place.

17. New Initiatives. The CFMS, in cooperation with organizations within and outside the CF, is at various stages of implementing a range of new initiatives intended to better meet the service members' in-garrison medical needs. The CFMS and its various partners should be recognized for the important contributions that they are or will be making in these areas. From the perspective of improving the management of in-garrison care, the review team sees enormous potential for Staff Assistance Visits, under the direction of CFMG HQ, to identify potential site specific improvements and serve as a catalyst for the migration of ideas across CFMS MOCs and organizations. Other important initiatives identified in the report are:

- Designated Provider Plan - a mechanism to assist the member and health care providers to secure health information and medical services from the civilian sector;
- DND/Veterans Affairs Canada (VAC) Centre for the Support of Injured and Retired Members and their Families - a point of liaison to assist members in their transition from being cared for by the military to obtaining services from VAC and other organizations;
- CF 98 Report on Injuries and Immediate Death - measures being taken to ensure the completeness and availability of this form when members need to seek pension benefits related to medical problems;
- Canadian Forces Member Assistance Program (CFMAP) - a confidential program focused on assisting members who have been victims of harassment, sexual assault or sexual harassment to seek timely psychosocial assistance;
- Operational Behavioural Sciences Centres - 5 centres located across Canada where members with illnesses or normal reactions to abnormal situations can go to receive confidential assistance. Post traumatic stress disorder is an illness that is highly prevalent in the military today and will be treated at these centres; and
- Information Guide for CF Health Services - a single guide that provides a comprehensive information package to members to assist them in understanding their medical entitlements and advising how to access them.

18. Benchmarking. The CF medical service was benchmarked with those services provided by three allied countries - United Kingdom, New Zealand, and the United States. There is a general trend among militaries to extract themselves from the business of running hospitals and partner more with the civilian sector. Other countries are experiencing similar recruitment and retention problems of MOs as the CFMS. There are also differing strategies being pursued such as the US primary care manager concept for

strengthening in-garrison care. Just as migration of ideas is important within DND/CF, the CFMS must also look to our allies to see if there are successful approaches being pursued by them which would be applicable in the Canadian context.

Overall Conclusions

19. The CFMS, staffed for the most part by highly skilled, fully competent, dedicated and committed military and civilian personnel, is a fatigued organization without clear strategic direction and perceived by some to be in a downward spiral. The CFMS has been downsized, restructured, reengineered, suffered high levels of attrition and turnover, and is experiencing consequent low levels of morale and diminished attitudes reflected in the service being offered to patients seeking in-garrison medical care. It is an organization with little reserve capacity for further change.

20. Recognizing that the CFMS has already been through dramatic changes in recent years, the review team has endeavored to offer meaningful and relevant recommendations, and an action plan which was developed by a special CDS Task Force has also been included in this report. The recommendations and action plan are intended to address correctable deficiencies and proposing more general strategies for approaching the issues where solutions are less clear. Making recommendations that would result in more radical outcomes, with potentially debatable benefits, could run the risk of negating some of the positive work done under Op Phoenix, and throwing an already stressed organization into further turmoil. The review team offers its suggestions and recommendations in the spirit of assisting the CFMS to make a strengthened contribution to the quality of life of CF members through its critical role of providing medical services.

PART 1 - CONCLUSIONS AND RECOMMENDATIONS RESULTING FROM THE CRS REVIEW

Conclusions Related to Strategic Direction

1.1 The review team has concluded that:

a. providers of health care services within the CFMS do not feel there is a clearly articulated strategic direction for the provision of medical services in the CF;

b. lack of strategic direction has left a change-fatigued CFMS wondering what the long term plan for the organization is and what are its strategic priorities for getting there;

c. development of strategic direction requires a thoughtful, interactive, iterative process that fully engages those who are clients, stakeholders and deliverers of the program; and

d. CFMS staff need to know that that this process is in train, that they will have an opportunity to contribute to the plan and that there will be comprehensive communications on the outcome of strategic direction for the Branch.

Recommendations Related to Strategic Direction

1.2 The review team recommends that:

a. steps be taken without delay to put in place a process to develop strategic direction for the CFMS Branch;

b. a communication strategy be developed to inform all members of the CFMS of the objectives and process related to formulation of 'Strategic Direction'; and

c. the casting of strategic direction be an exercise that is inclusive of all aspects of Health Services and not restricted to medical services.

Conclusions Related to the Impact of Op Phoenix on In-garrison Care

1.3 The review team has concluded that:

a. implementation of Op Phoenix has had both positive and negative impacts;

b. from a positive perspective, putting in place aspects of Op Phoenix, such as accessing services from the civilian sector, has educated the CFMS on challenges that may not have been fully appreciated at the planning phases of the reengineering effort; and

c. on a more negative note, there has been a partial and fragmented approach to implementation of the Op Phoenix concepts. The process, which has been extended over a prolonged period of time, and is not yet complete, has been very difficult for medical service providers and their clients to the point that issues of morale and trust are surfacing in significant ways. The result has been an erosive effect in these areas from which the review team believes it will take the CFMS considerable time to recover.

Conclusions Related to the Standard of Health Care Provided to CF Members

1.4 The review team has concluded that:

a. the CFMS, through its enabling documentation (QR&Os) and Spectrum of Care publication, has the authority to provide health care services which, at a minimum, are comparable to those offered under provincial health care plans;

b. in areas relevant to the occupational aspects of the CF, the comprehensiveness of medical coverage actually exceeds that provided to "insured Canadians";

c. focus group and interviewee responses acknowledge this coverage, but indicate that the CFMS falls short in the delivery of this capability due to administrative burdens, the perceived decline in service levels due to delays imposed by interfacing with provincial health systems, and customer service levels offered by the CFMS; and

d. from a medical skills, health treatment and spectrum of care perspective, the CFMS is comparable to provincial health care services available to all Canadians. However, the manner in which these services are delivered to the CF member appears to fall short of the civilian health care sector. As determined by the Review Team through interviews and focus groups, CF medical personnel have collectively admitted to a low level of morale

coupled with a lack of professional challenge, which has contributed to an approach to their work reflected in patient care and the patients' perception of the care they are receiving.

Recommendations Related to the Standard of Health Care Provided to CF Members

1.5 The review team recommends that:

a. CFMS professional medical staff be given clear direction on the level of care that they are expected to provide in-garrison. This would include a statement on the scope and range of services that are to be provided;

b. process re-engineering be conducted at the Health Care Centre/Base Clinic-level to evaluate current administrative procedures and, where they are lacking, make necessary adjustments to improve customer service at all in-garrison clinical settings;

c. an option for trans-regional accessibility to civilian health care treatment be made available to CF patients in order to align operational and medical priorities with optimal availability of care to reduce access delays. Judgements on making trans-regional treatment available to members should be made on a case by case basis;

d. appoint an external organization to conduct independent audits of CF health care facilities (in addition to the Staff Assistance Visits (SAVs) conducted by CFMG/DGHS staff) to measure and benchmark delivery standards; and

e. consideration be given to seeking provincial certification/accreditation of CF health care facilities from the Canadian Council on Health Service Accreditation to assure CF patients of comparable care to that which is available through provincial / civilian sector facilities.

Conclusions Related to Continuity of Care

1.6 The review team has concluded that:

a. continuity of care is a fundamental concept in the practice of family medicine and is not perceived as being delivered to the extent that it could or should be in the CF;

b. allied military and paramilitary organizations are implementing similar strategies to those being pursued by the CFMS by striving to improve continuity of care for their personnel through greater use of civilian medical resources. There are other strategies that some of the allies are

implementing in addition to civilianization that may warrant consideration by Canada. It would be worthwhile for the CFMS to be aware both of initiatives that worked for other defence forces and those that didn't, in order to derive maximum benefit from these other experiences;

c. achieving continuity of care is generally considered by the medical profession to be more important in the treatment of chronic cases than in the treatment of ailments of a more routine nature; and

d. the extent to which continuity of care is not achieved in the military impacts patient morale and, at times, threatens the quality of care being received.

Recommendations Related to Continuity of Care

1.7 It is recommended that:

a. initiatives to facilitate the hiring of civilian physicians for temporary and indeterminate assignments, such as the Designated Provider Plan and other strategies, be pursued as a matter of priority;

b. strategies that other nations have pursued (e.g., primary care manager in the US military) be examined for their applicability either site-by-site or on a more national basis in the CFMS;

c. Surgeon General highlight for all CFMS staff through the Branch Newsletter, personal site visits, the Defence Information Network web site, and other venues, the importance of achieving continuity of patient care to the extent practical and implementable in the in-garrison setting, with the highest priority being placed on members with chronic ailments;

d. procedures be developed at health care centres which will optimize the opportunity to provide continuity of care to the patient and implement CFMO 27-02 to the maximum extent possible;

e. steps be taken to ensure that continuity of care is featured as a curriculum item in all CF courses that have application to clinical and administrative matters relating to the delivery of in-garrison care; and

f. CFMS personnel and leaders in the operational chain of command be reminded of their leadership responsibilities to support CF members in receiving continuity of medical care.

Conclusions Related to the Administration of Temporary Medical Categories

1.8 The review team has concluded that:

a. the temporary medical category concept is premised on sound rationale;

b. while the TMC process is sound, there are administrative aspects that could be improved upon for the benefit of the member and the CF;

c. patients who are currently on or who have been on TMCs, for the most part do not have a good understanding of the process;

d. members are distrustful of the TMC process from a career implications perspective;

e. members often feel ostracized by their peers and sometimes their superiors when they are assigned a TMC;

f. while members had varying views and opinions on how quickly they wanted decisions taken related to their TMCs, it is generally to the benefit of the member and the CF for these matters to be resolved in a timely way;

g. a combination of significant numbers of members assigned repeated TMCs and a sparing use of the medical patient holding list serves as a major frustration for COs who are trying to do the right thing for the patient, but must also accomplish the operational mission with reduced resources;

h. MOs may be subjected to pressures from members and more senior COs on decisions related to TMCs - these pressures pose significant ethical dilemmas for the MOs;

i. while lack of leadership involvement can be linked to a number of cases where the TMC process has not functioned as expected, COs and supervisors recognize that the process is an administrative one and they have a significant role to play to make sure it functions well;

j. IM/IT offers the potential to assist in the administration of TMCs and some standalone systems in the field are being developed, used and contributing to the administration of TMCs;

k. there are significant costs attached to having members on TMCs; and

l. to their credit, D Med Pol staff have made considerable progress in recent months to reduce the backlog of TMC files referred to NDHQ to manageable levels.

Recommendations Related to Temporary Medical Categories

1.9 The review team recommends that:

a. efforts be made to improve patient knowledge and awareness levels on temporary medical categories;

(1) all CFMS clinical staff should be knowledgeable on the TMC concept and process and be ready to answer frequently asked questions on TMCs; and

(2) supplies of the brochure recently issued by D Med Pol on TMCs should be made readily available in medical facilities where in-garrison care is provided to CF members and copies should be distributed freely to members;

b. leaders be sufficiently involved in the administration of TMCs so that the member is not administratively put off to the side, without sufficient supervision or support;

c. leaders fulfill their responsibilities to ensure that colleagues of the member on TMC are aware of the process and understand why TMCs are used;

d. as a general rule, decisions related to the administration of TMCs be taken in as timely a way as possible and practical, taking account of the best interests of the patient, the unit and the CF;

e. training venues that introduce MOs to the practice of medicine in the CF and address the concept of TMCs, make provision for educating the MO not only on mechanics of TMCs, but also on some of the related human resource dynamics; and

f. when Surgeon General and other CFMS personnel are briefing various forums of CF leadership, they take the opportunity to highlight leadership responsibilities related to TMCs and continuity of care.

Conclusions Related to Command and Control of Delivery of in-Garrison Care

1.10 The review team has concluded that:

a. lack of clarity of responsibilities, authorities and accountabilities is having an impact on the delivery of the care;

b. delivery of in-garrison health care is very dependent on the successful coordination and integration of the resources of three separate chains of command. This structure is highly influenced by personalities and differing priorities rather than organizational principles;

c. the current command and control structures within the CFMS hinder the DGHS / CO CFMG from providing corporate, strategic direction or leadership to the bulk of medical resources which belong to the environmental commands;

d. lack of unity of command by the HCC over resources providing in-garrison care impact the ability of the HCC to effectively administer the base health care facility and provide patient focused service; and

e. the existing mandate of the CFMS as provided for by the Op Phoenix concept is best served by the current structure, at this time.

Recommendations Related to Command and Control of Delivery of In-Garrison Care

1.11 It is recommended that:

a. the commitment of CFMG and Command resources in support of in-garrison patient care be stabilized. Service-level agreements between CFMG detachments, Command units and the CF medical facilities should be established to ensure minimum resource commitments in support of in-garrison care;

b. improvements to the delivery of in-garrison care be achieved in the immediate timeframe through administrative, procedural and staffing adjustments rather than structural realignment of the function;

c. the responsibilities, authorities and accountabilities for the provision of in-garrison patient care be clarified between CFMG staff, Command staff, Base Commanders and Health Care providers;

d. HCC responsibilities focus solely on the provision of in-garrison care for CF members and the operation of the CF medical facility. Operational and other CF related medical issues that were formerly addressed by the Base Surgeon pre-OP Phoenix should be addressed by Command medical staffs; and

e. consideration be given in 18 to 24 months to establishing a centralized health services organization.

Conclusions Related to CFMS Resources, Establishment and Staffing

1.12 The review team has concluded that:

a. the provision of in-garrison health care services remains highly dependent on the availability of CFMS uniformed personnel. Arrangements with the public health care sector have not yet matured to meet the objectives envisioned by Op Phoenix;

b. workload and case load statistics and data are not being gathered to permit analysis to determine minimum staffing requirements for both uniformed and civilian health care providers;

c. a decrease in the number of physicians relative to the Canadian population has severely impacted the availability of and access to the public sector health care sector by the CF;

d. the ratio of the number of general practitioners and medical specialists (established positions) to the CF patient population, generally exceeds the ratios of similar occupations in the civilian sector;

e. attention to management and utilization of medical specialist resources, including staffing currently unfilled positions will yield greater benefits to the provision of in-garrison services than increasing the number of established positions;

f. the distribution of a CF population over a wide geographical area (coast to coast), may negate the benefit of having more favourable ratios of medical professionals to patient population than exist in the civilian sector;

g. the CFMS' capability to provide health care services is augmented by accessing services in the civilian sector, thereby increasing the leverage of a dedicated CF medical service;

h. shortfalls of personnel in the CFMS do not equate to insufficient established positions;

i. current shortfalls in the medical assistant occupational category will have a future impact on those medical specialist trades which draw on the medical assistant occupational category;

j. health care coordinators are lacking managerial and administrative training specifically to manage the CF medical facility function;

k. at a time when significant shortfalls are forecast in the availability of GDMOs to provide in-garrison care, greater involvement of the health care administrator in the role of managing activities in the CF medical facility function would optimize the availability of GDMOs for clinical duties; and

l. there is insufficient consideration of command leadership experience in the selection of candidates to fill senior management positions in the CFMS.

Recommendations Related to CFMS Resources, Establishment and Staffing

1.13 It is recommended that:

a. workload, caseload and other performance measurement data be gathered at all CF sites providing in-garrison medical care;

b. existing established CFMS positions be staffed before additional positions are authorized for the respective MOCs;

c. strategies be developed to address current shortfalls in the medical assistant occupation;

d. a two-pronged strategy be pursued to address managerial deficiencies in the CF medical facilities;

(1) HCCs be given appropriate management training before assuming the position and on-going training while they are in the post, and

(2) HCAs and HSOs located in the health care centres assume more of the administrative responsibilities related to delivery of in-garrison care, thereby freeing up clinical practice time of the health care coordinator.

e. position analysis statements of senior positions in the CFMS be examined by appropriate staffs to determine the skill sets required to perform the duties of the respective positions.

Conclusions Related to Recruitment and Retention of Medical Officers

1.14 The review team has concluded that:

a. as the attrition rate for MOs is significantly higher than historical averages, at the same time as little interest is being expressed in traditional entry venues (Medical Officer Training Program), the CFMS will be facing significant military physician shortages over the next several years;

b. the CFMS has a strategy for attracting direct entry officers and is implementing it; and

c. there is no specific strategy being pursued to retain CF medical officers, yet MOs have a range of concerns that could be addressed to make being an MO more attractive.

Recommendations Related to Recruitment and Retention of Medical Officers

1.15 The review team recommends that:

a. the effectiveness of the bonus that has been put in place to attract DEOs be assessed periodically. If it is determined not to be meeting the objective then it should be reassessed and alternate strategies developed;

b. strategies be pursued to ensure an equitable sharing of deployment assignments among GDMOs and specialist MOs;

c. the CFMS represent or otherwise support CF MOs in discussions with various provincial and territorial medical licensing bodies on an as required basis on matters unique to serving CF medical officers (licensing issues, maintaining billing numbers etc.);

d. with the assistance of expert consultant support, the CFMS undertake a study to determine appropriate ways of encouraging clinicians to make a career of practicing clinical medicine with the CF;

e. a validation of the training being provided to MOs be completed to ensure that:

(1) MOs are receiving sufficient and appropriate maintenance of competence and CME to meet their operational and in-garrison responsibilities, and

(2) complete training records are maintained and available to leaders who will be taking decisions on the deployment of MOs (trauma, burns, geriatrics, pediatrics etc.); and

f. the CFMS leadership examine ways to increase the profile of the contribution of MOs in the CF.

Conclusions Related to Morale, Attitude and Capacity for Change in the CFMS

1.16 The review team has concluded that:

a. low morale exists in the CFMS on a widespread basis, and is negatively impacting the attitudes of health care personnel in the clinical setting;

b. reasons for low morale are varied and include but are not restricted to:

(1) change fatigue being felt at all levels of the CFMS,

(2) lack of understanding where the organization is headed strategically,

(3) CFMS personnel sensing a lack of appreciation or understanding from the CF of the demands that have been placed on them,

(4) a perception that the corporate focus on health care has shifted from patient care to the task of implementing OP Phoenix,

(5) leadership concerns within the CFMS, and

(6) heavy workload, including in-garrison and operational responsibilities, to which there appears to be no end in sight; and

c. some CFMS personnel have expressed the view that they no longer have the reserves to continue to do their jobs and to cope with further change initiatives. While there are significant initiatives yet to be implemented to strengthen the provision of in-garrison care, the success of these initiatives will be dependent on the capacity of the CFMS health care professionals who must implement the changes necessary for the long term benefit of the CF.

Recommendations Related to Morale, Attitude and Capacity for Change in the CFMS

1.17 It is recommended that:

a. an assessment be made of the amount of assistance that will be required to enable implementation of the recommendations of the CRS review; and

b. the Department support the requirement, once validated, with appropriate financial and human resources.

Conclusions Related to the Administration of In-garrison Patient Care

1.18 The review team has concluded that:

a. patients take a holistic view of their medical care which includes the administration associated with it;

b. CF patients who experience poor administrative practices when receiving in-garrison medical care frequently interpret those problems as poor medical care being provided to the member;

c. not all health care centres have reasonable records management tools in place (Bradma Plates or equivalent) to reduce administrative workload and minimize opportunities for error;

d. lack of internal policy and procedural guidance on the handling of patient files has left CF in-garrison units with very wide latitude in this important process;

e. given the sensitive and very personal nature of medical information it is necessary that protocols be in place for the handling of patient files within the CFMS;

f. the high turnover of medical personnel flowing through the CF medical facilities, particularly Med As who are responsible for the administration and management of the files, has the potential to negatively impact on how files are managed;

g. placing greater responsibilities on the student for learning patient record management through self-study rather being trained under the guidance of an instructor has increased the risk that the Med A may not cover all of the material or, if they do, may not understand it all. While this may be an economical way to deliver the training, it may be less effective and this would never be known without an appropriate validation process;

h. patients' administrative needs are not consistently being provided for when visiting CF in-garrison facilities leaving members with a poor impression of the CFMS and consequently eroding their confidence and trust in the system serving them;

i. medical situations are arising that are not being readily provided for by either the CFMS or the civilian medical system;

j. while these issues may arise due to local circumstances that exist at a particular time similar problems are surfacing in multiple locations; and

k. while workable (not always ideal) solutions are generally found, the more that HCCs know about how others have handled similar situations, the better placed they should be to respond appropriately when required.

Recommendations Related to the Administration of In-garrison Patient Care

1.19 It is recommended that:

a. CF health care centres examine their internal administrative functions and processes to ensure that:

(1) such basic information management tools as Bradma Plates or equivalents are in place, and

(2) other mechanisms for streamlined processing of in-garrison patients are in place and functioning as intended;

b. the CF policy and procedural guidance on handling of patient records be made sufficiently clear and complete as to provide an appropriate level of protection for the documents, provide a reasonable degree of assurance of the integrity of the information contained there in and provide assurance to the member that their medical information is being adequately safeguarded while in the custody of the CFMS and civilian medical service providers;

c. standard operating procedures be put in place and kept up to date at all CF medical facility sites to assure consistent high quality administration supports the delivery of in-garrison medical care;

d. HCCs track medical incidents that have arisen that cannot be accommodated through CF in-garrison patient care arrangements or the civilian system. These incidents should be advised to Surgeon General for his / her information; and

e. sharing of how these experiences were handled should take place at forums where HCCs are brought together with migration of ideas being one of the objectives of the session.

Conclusions Related to Mechanisms for Obtaining Civilian Physician Services In-garrison

1.20 The review team has concluded that:

a. the decision to realign the CFMS organization structures to support a more operational focus without having systems in place to backfill MO positions with contract civilian physicians has placed an enormous burden on HCCs responsible for the delivery of in-garrison patient care;

b. this burden has in turn been passed on to military MOs who have not only had to respond to the demands of an increased tempo of operations, but have also had to make further personal sacrifices to ensure that patient care continues to be delivered in garrison (recalled from leave, leave cancelled, MO on TMC supposed to work half days working 12 to 14 hour shifts etc.); and

c. use of stop-gap measures for contracting civilian doctors has become a matter of routine in most CF medical facilities in most cases is unfair to the contract physician and contravenes accepted public service hiring practices as provided for in the Public Service Staff Relations Act. For many CF medical facilities the DPP is not scheduled for implementation for sometime.

Recommendations Related Mechanisms for Obtaining Civilian Physician Services In-garrison

1.21 It is recommended that:

a. the Surgeon General with the support of the CF, progress implementation of the DPP at CFMS in-garrison medical facilities across Canada as expeditiously as is reasonably achievable; and

b. pending implementation of the DPP, CF sites providing in-garrison care review the appropriateness of continued use of the DND 2058 form when engaging temporary civilian physicians. If a more appropriate mechanism cannot reasonably be put in place before inception of the DPP, then HCCs should, at the very least, advise civilian doctors currently on contract with the CF that the DPP is coming and what the implications of that change could mean for them.

Conclusions Related to Securing Specialist Services for Delivery of In-garrison Care

1.22 The review team has concluded that:

a. as a general practice, it would likely not be appropriate for DND/CF to be seen to be jumping the civilian sector queue by sending CF members to fee for service health care providers; and

b. there are strategies that could be pursued in order to obtain specialist services quickly under extraordinary circumstances. Two sources are through purchasing blocks of physician time and trans-regional treatment.

Recommendations Related to Securing Specialist Services for Delivery of In-garrison Care

1.23 It is recommended that:

a. statistics be gathered and analyzed to determine areas where the CF generates unusually high numbers of cases requiring certain specialty care from the civilian sector. Where regular patterns exist and there is difficulty securing that care then arrangements should be made to purchase block amounts of physician time; and

b. in non-emergency situations, on a case-by-case basis, assessments be made to determine if extraordinary steps should be taken to secure specialist care for the member, outside his or her geographical posting area, on a more timely basis than could be provided locally.

Conclusions Relating to Provision of First Responder Care In-garrison

1.24 The review team has concluded that:

a. while first responder care is a peripheral issue for the medical services branch, the fact that confusion exists among those responsible for provision of in-garrison care makes it an issue that could impact the level of patient care provided the soldier, sailor and air man or woman; and

b. the Surgeon General has a responsibility to provide medical advice to the CDS on the adequacy of the current arrangements for the provision of first responder care. He should be able to tell the CDS if the CF member is receiving first responder care that is equivalent to that being received by the average Canadian and, to the extent that it may fall short, the degree of increased risk for the member.

Recommendations Relating to Provision of First Responder Care In-garrison

1.25 It is recommended that:

a. Surgeon General be prepared to offer medical advice to the chain of Command, including Base Commanders, on matters related to the delivery of first responder care in-garrison;

b. as part of the staff assistance visits to CF in-garrison locations the Director Health Services Delivery include the adequacy of first responder care as an area to examine. Recommendations resulting from such assessments should serve as a point of discussion with the Base Commander, the Health Care Coordinator, Fire Chief and any local authorities that might be impacted. Appropriate actions should result based on the direction of the Base Commander; and

c. communication be issued at the base/wing/formation level explaining the local arrangements for delivery of first responder care.

Conclusions Related to Migration of Ideas

1.26 The review team concluded that:

a. there is little opportunity within the CFMS to readily share innovative ideas and solutions that would contribute to the efficient and effective delivery of in-garrison health care;

b. CFMS personnel are generating good ideas, particularly ones relating to data base management of patient information, and are putting those ideas into place at some sites. Sharing of these IM/IT ideas offers the opportunity for leveraging on ideas that have already been developed; and

c. the sharing of ideas will not occur on its own, but will require a deliberate effort in order to derive maximum benefit from this concept.

Recommendations Related to Migration of Ideas

1.27 It is recommended that:

a. CFMS personnel ensure that, when setting up training programs, workshops, conferences or other forums where branch members will be brought together, that some time is set aside for sessions where sharing of ideas could take place; and

b. the Staff Assistance Visit (SAV) capability that has recently been stood up in the Assistant Chief of Staff Health Services Delivery (ACOS HS Del) be utilized to the fullest extent possible as an impetus and catalyst behind the migration of ideas across the CFMS.

Conclusions Related to Information Management/Information Technology Support to CF Health Services

1.28 The review team has concluded that:

a. the CFMS does not have an adequate IM/IT system to provide real time knowledge of the health status of its operational units to support operational roles;

b. an integrated health information system is needed to support the CFMS due to the high mobility of the CF population, operational requirement for the health status of the CF, increased reliance on the civilian health care sector and the requirement to manage a uniform quality of health care delivery at all CF sites;

c. the CF in-garrison health care delivery models have not been adequately established and refined to facilitate the development of a CFMS IM/IT infrastructure;

d. increased integration between the CFMS in-garrison and the civilian health care sectors raises security issues as the CF has higher security standards for health information than the civilian sector; and

e. the ability of the CFMS to make appropriate management and resource allocation decisions has been constrained by the lack of available health care data, and workload volumes and statistics.

Recommendations Related to Information Management/Information Technology Support to CF Health Services

1.29 It is recommended that:

a. the in-garrison health care delivery model be established and be put in place to determine the necessary IM/IT support that will be required;

b. the CF develop policy related to acquiring, handling and release of health information for CF members both internally and externally;

c. the information requirements to support CF occupational health requirements be determined, along with the methods on how this information will be acquired and controlled;

d. the CFMS update and streamline business and management practices currently in use in order to streamline administrative processes and improve handling of patient information in the clinical setting;

e. CFMS business practices be adapted to take advantage of commercial off-the-shelf health care software applications to reduce design and development costs and facilitate integration with civilian health care providers;

f. plans be progressed to implement IM/IT solutions to support the CFMS that can be quickly put into place with the flexibility to meet changing requirements and conditions in both the CF and civilian health care sectors; and

g. a security risk assessment be conducted with regard to CF health information to facilitate the necessary links to the civilian health care sector.

General Conclusions Related to New Initiatives

1.30 The review team has concluded that:

a. the CF and the CFMS have recognized that their have been systemic deficiencies in DND/CF related to provision of in-garrison care and quality of life for members. By embarking on these new initiatives CF members should realize that their feedback has been heard and is being taken seriously;

b. putting these new initiatives in place is not an isolated CFMS effort, but rather calls for cooperation support and assistance from other areas of DND/CF and other government departments. One area where the CFMS was in particular need of support at the time of writing this report is from ADM (Mat) and PW/GSC procurement / contracting staffs to assist in progressing the DPP;

c. these new initiatives provide a start point down a long road to regaining the trust and confidence of CF members in the senior leadership's commitment to providing appropriate in-garrison medical care and taking significant steps to improve the service member's quality of life. Announcements and delivery of new initiatives will not be sufficient on their own. CF members not only expect high quality in garrison medical care they need to perceive that they are receiving it. Continuity of care, appropriate medical treatment and associated administration while on TMCs, proper management of their patient records, courteous professional treatment by staff providing direct and ancillary services related to in-garrison care all need an appropriate level of attention to assure required levels of patient trust and confidence; and

d. the CFMS and its associated CF and VAC partners deserve credit for pursuing initiatives that have proven to be successful in the civilian sector and recognizing their applicability for the military (e.g., the 1-800 call centre concept for triage and other patient assistance has been extremely popular and well-received in the province of New Brunswick and is now being looked at seriously for Ontario).

Conclusions Related to Benchmarking the Canadian Forces Medical System

1.31 The review team has concluded that:

a. there is a widespread reliance on the civilian health care sector by other military organizations to provide in-garrison medical care in order to preserve a capability to deploy uniformed medical personnel to support operational missions;

b. military medical establishments are primarily based on identified operational requirements, resulting in a need to supplement in-garrison care with civilian resources;

c. timely access to medical care is a major concern of the service member and remains a goal of the military health service;

d. socio/psychological issues, and strategies to deal with them, are a significant concern of military health services;

e. attrition of physicians is high (40 per cent to 80 per cent) after completion of obligatory service in all organizations benchmarked with the CFMS; and

f. all organizations included in the benchmarking review indicated their military medical organizations were involved in developing strategies and new initiatives in order to provide appropriate health care services to military members while preserving the capability to meet operational medical commitments.

PART 2 - ACTION PLAN RESULTING FROM THE CDS TASK FORCE

CDS Task Force - Health Care Support to the Canadian Forces
Putting the 'Care' back into 'Health Care'

EXECUTIVE SUMMARY

2.1 When the CDS was briefed on the draft CRS report on the Review of the Medical Services, he concluded that it could not be released without an accompanying action plan and leadership commitment to make it happen now. To develop the action plan, he assembled a Task Force comprised of military health care professionals and civilian advisors (Annex A). The Task Force went beyond the 59 CRS recommendations and addressed the areas that CRS had identified as requiring further study. The action plan produced contains hundreds of recommendations for action.

BACKGROUND

2.2 The picture painted by CRS is not a pretty one. Yet, it is clear that it is just the tip of the iceberg. The medical system is broken. When the Task Force finished reading the CRS report and completed its first week of in camera briefings, the members were overwhelmed. It did not matter where we looked, something was either badly broken or barely hanging on by a thread. It made us wonder when this was going to start having a serious impact on the Medical Service's ability to provide adequate operational health care support - assuming it did not already.

2.3 Before we move on, lets take a moment to reflect on the Canadian and Military standards of health care. We often hear that the Canadian standard of health care is one of the highest in the world. What is the Canadian standard? Is it the same in Tuktoyaktuk as it is in Toronto? Intuitively, we know that there is a significant difference between the standard available at these two locations. Yet, both are representative of the Canadian standard of care.

2.4 Even when the CFMS was considered 'rich and elitist', the military capability was falling short of the expected or assumed Canadian standard. Why? Because to be able to provide operational health care support where CF members happen to be, we employ some multi-skilled but unlicensed personnel, some of the drugs we administer are unlicensed, and not all of our medical equipment is CSA approved. For the most part, as a training vehicle, we operate in garrison as we do in operations. This is perfectly acceptable under federal statute.

2.5 Whereas before we were able to maintain the gap between the two capabilities at a reasonable level, the closure of CF Hospitals has caused the gap to widen sharply in the last few years. This is not to suggest that we should go back to the ways in which we used to operate. However, it presents a phenomenal challenge. On the one hand, the civilian trend is expected to be a positive one as new techniques, equipment and drugs are developed and implemented and, as governments reinvest significantly in what many consider to be an underfunded health care system. On the other hand, as unlicensed military personnel cannot work in civilian facilities to maintain clinical competence, the military downward trend is expected to continue and possibly accelerate as skills, knowledge and availability of certain groups of uniformed health care personnel continue to dwindle and deteriorate.

LEGAL BASIS FOR THE CF HEALTH CARE MANDATE

2.6 The CF health care mandate is to provide the health care support necessary to sustain a multi-purpose, deployable, combat capable force across the full spectrum of military scenarios.

2.7 Health is an amorphous field that is distributed to the federal or provincial level of government depending on the purpose and effect of the particular measure at issue. It is for this reason that section 91(7) of the Constitution Act, 1867, serves as the constitutional basis for the CF's health care mandate.

2.8 The 1984 Canada Health Act, the purpose of which is to set out the conditions under which the Federal Government will transfer health care money to the Provinces, explicitly defined CF members out of the definition of 'insured persons'. To have CF personnel included in the definition of 'insured persons' would require Parliament amending the Canada Health Act. The legislation of nine of the ten Provinces provides for the exclusion of anyone having entitlement to health care under federal statute. Furthermore, the legislation of Alberta, Saskatchewan and Prince Edward Island specifically exclude CF members and would also have to be amended accordingly.

2.9 To approach the provinces, the Department would require a bureaucratic and political consensus with Health Canada, PCO, Intergovernmental Affairs, TB, Finance, Corrections Canada, and the Solicitor General (on behalf of the RCMP). The Federal Interdepartmental Health Policy Committee, chaired by Health Canada, is the forum through which the required consensus would have to be reached.

2.10 In short, DND is legally bound to provide for the health care needs of CF members, at home or abroad, in a universal, portable, comprehensible, accessible and publicly administered way. How health care is provided to CF members is left to DND to determine.

RATIONALE FOR A UNIFORMED HEALTH CARE SERVICE

2.11 The physical and mental, health and fitness of CF members are inextricably linked to the readiness, effectiveness, and efficiency of the military as a fighting force. Before sending troops into harm's way, the Chain of Command must know, not only the physical and/or mental health limitations which may preclude successful completion of military tasks, but also the health and fitness levels and employment limitations of CF personnel. In addition, military training and operations frequently result in serious injuries necessitating immediate access to life-saving health care resources. The military itself is in the best, if not unique, position to provide the necessary timely care.

2.12 This is not to say that uniformed health care providers have to be able to do it all themselves. It is clear that for most of the CF member's career, health care will be provided through a partnership between civilian and uniformed health care providers. However, just as CF members have done, uniformed health care providers have made the informed choice that they would give up their individual rights and freedoms by placing 'Service before Self'. This premeditated decision of unlimited liability to serve, allows uniformed health care providers to serve CF members, anywhere and anytime. They can go where our civilian counterparts sometimes cannot go. They are trained and ready, as other CF members are trained and ready, to respond to our country's demands.

CONTINUITY OF CARE

2.13 Concern over continuity of care, or lack thereof, is the main issue that led the CDS to ask CRS to conduct a *Review of the Medical Services*.

2.14 We all agree, the broken minds and broken bodies that populate the CF require nurturing. Symptoms are complex, treatment regimes comprehensive. For CF members, the ability to establish a strong, stable therapeutic relationship with health care providers is vital. For DND, the responsibility to provide a minimum of 'continuity of care' is fundamental.

2.15 To provide continuity of care, especially in the many under-serviced areas where the CF operate, DND needs to provide a health care structure that offers a minimum of stability, that is accredited, and that is managed with clearly articulated direction and guidance.

2.16 How do we go about establishing a stable health care structure? First, the Task Force undertook to articulate the areas of health care where uniformed health care providers should concentrate their effort. Annex B summarises the outcome of that work. As you can see, civilian employees or contractual arrangements, especially at home, could take care of approximately 60 per cent of the mandated work. Who does the work right now? Often nobody. This affects all areas of health services delivery, at home and abroad. Civilian resources are required to offset these shortfalls.

2.17 Second, the Task Force undertook to articulate the essential in-garrison health care functions that, if provided in a stable environment by means of a core civilian capability, would have the greatest impact on continuity of care. Forces-wide, Certified Health Service Executives should manage clinics. The intent would be to create a network of Certified Health Service Executives to enhance accessibility, both locally and trans-regionally. In addition, there should be a number of civilian general practitioners, nurse practitioners, and/or care managers, at each site for the larger sites or in every region, to cater to those individuals who require more nurturing by virtue of the complexity of their medical conditions. Finally, core civilian personnel should perform the reception, appointment, medical records and patient tracking functions. Civilian resources, the number of which will be site specific, are required to offset current shortfalls and ensure continuity. Additionally, this presupposes the existence of hiring mechanisms that facilitate and support the process, and that ideally, would not see us competing against provinces for scarce health professionals.

2.18 Third, the Task Force tackled the standard of in-garrison health care. Evidence presented to the team indicates that the standard of in-garrison health care needs serious improvement. To address this concern, the team resolved to establish partnerships with the Canadian College of Health Service Executives and with the Canadian Council on Health Services Accreditation. The latter organisation surveys establishments and declares them 'Accredited' providing they meet a set of standards. The idea would be to confirm the standards, survey all sites to determine the capability gap and resource it, thus restoring the standard of in-garrison health care. We have yet to determine what resources will be required to offset these shortfalls.

2.19 Fourth, the Task Force considered other ways to enhance accessibility and relieve shortages such as the Designated Provider Plan. With the advent of the DNC/VAC MOU on 1 April 2000, the Designated Provider Plan will open up a network of caregivers to care for the health care needs of CF members. This will provide some relief, however, it will be of little help to those located in under-serviced areas.

2.20 Reservists are a primary pool of resources from which to draw to enhance accessibility and relieve shortages. Health care professionals, who join the Medical Reserve, hold the same licenses and train to the same standards as their Regular Force colleagues. In addition, they are networked or employed, often full-time, in the civilian health care sector. Significant benefits would accrue from the amalgamation of Reserve and Regular Force health care personnel into a unified military component of the total health care team.

2.21 Fifth, the Task Force considered the requirement for maintenance of clinical competence of health care providers. As indicated previously, the gap between the civilian and military health care capabilities is widening rapidly. The solution is to secure maintenance of clinical competence opportunities in the civilian community for uniformed health care providers. In partnership with the Canadian College of Health Service Executives, it is proposed to enlist the support of some of the largest Canadian health care organisations to secure maintenance of clinical competence opportunities. To

this end, we must move forward with the licensing of medical/physician assistants or with the development of a licensed alternative to this occupation. In addition, we must also find a way to deal with provincial-licensing barriers – another impediment we will have to overcome.

2.22 Finally, the Task Force considered the complexity of current command and control relationships and its impact on existing departmental vertical and horizontal accountability structures. It surmised that there is a need to centralise the capacity to command and control health care resources and develop the required accountability framework.

2.23 Health care concerns touch everyone, irrespective of service affiliations. Without healthy sailors, soldiers and air personnel, the CF cannot deploy. A corporate account has already been set up to finance the delivery of health services to CF members. Because of his ready access to the full spectrum of uniformed health care expertise, DGHS already does most, if not all of ADM (HR-Mil)'s health policy and managing authority work. The latter will be especially true with the Medical School becoming a unit of DGHS instead of CFRETS. DGHS is the joint force generator of the CF health care capability. He has to be able to support the navy and provide diving medicine support. He has to be able to support the army and provide operational health care support anywhere on the non-linear battlefield. He has to be able to support the air force and provide flight medicine support. Finally, by virtue of his unique role, DGHS has to be able to work at the strategic, operational and tactical levels. DGHS is in a unique position that argues for his becoming a Level One. Designating DGHS as a Level One in the NDHQ hierarchy would send CF members the key message of the importance DND attaches to health care issues.

KEY ENABLERS

2.24 Putting the 'care' back into 'health care' is a massive undertaking on par if not bigger than our Quality of Life initiative. It will take a lot of concerted effort and it will take time. What are the essential enablers to success? First, a Senior Review Board comprised of the CDS/DM and selected DMC members. Second, there is a requirement to create a PMO, with CRS oversight. Third, the Chain of Command must get involved in the design and implementation of command and control arrangements that will enhance the provision of the health care support necessary to sustain a multi-purpose, deployable, combat capable force across the full spectrum of military scenarios. Fourth, there is a need to partner with essential civilian health care organisations such as the Canadian College of Health Service Executives and the Canadian Council on Health Services Accreditation. Finally, there is a need for a strong Communications Approach, which has been developed by DGPA.

COMMITMENT

2.25 In the Task Force's opinion, it is not the work ethic, dedication or professionalism of Medical Branch personnel that resulted in the problems identified by CRS. Before restructuring, uniformed health care providers lacked operational focus, as they were too busy providing in-garrison health care. Post restructuring, uniformed health care providers found that they had fewer resources to provide in-garrison health care; an impossible command structure; a reduced and heavily scrutinised budget; a downsized and restructured civilian health care system, which they had planned to partner with; and sicker people to treat – reflective of the effect of multiple and often stressful deployments.

2.26 The proposed plan provides a well-reasoned strategy for delivery of '*Health Care – One standard, anytime, anywhere*'.

ANNEX A

CDS TASK FORCE - MEDICAL SUPPORT TO THE CF

Team Leader	-	Col Lise Mathieu, EA/CDS
Participants	-	Col D. Read, SA/VCDS Col D. St-Amour, COS/CFMG Col Quinn, Comd 41 Bde LCol H. Jaeger, CFLSC LCol B. O'Rourke, CFMG LCol M. Roy, CFMG LCol W. Franklin, MARPAC LCol MacGregor, MARLANT Cdr Slaunwhite, HCC CFSU (O) LCdr H. Cunningham. 3 HSOTU Halifax CWO MacBride, MARPAC
Advisors	-	M. Gaston Levac, President Canadian College of Health Service Executives M. Hubley, CRS M. Black, CRS M. McEachern, CRS LCol B. Boudreau, DGPA
Team Support	-	Maj P. O'Grady, CFMG Ms J. Maloney, SO3/CDS

ANNEX B

PRIORITY OF EFFORT

Operational health care support 1. Mil 2. Civ

Health Prevention

Preventive Medicine General		Collectively – Mil
Hygiene	Civ	
Sanitation	Civ	
Pest Control	Civ	
Public Health/Mandated Programs	Civ	
Industrial Hygiene		
In-Garrison	Civ	
Deployed	1. Civ 2. Mil	
Operational Medicine		
Flight Surg/Diving Medicine	1. Mil 2. Civ	
NBC	1. Mil 2. Civ	
Policy/Plans	Mil	
Infectious Disease Control	1. Mil 2. Civ	
Epidemiology/Disease Tracking	Civ	
Medical Intelligence	1. Mil 2. Civ	
Regulatory Affairs	Civ	
R & D	Civ	
Human Factors/Ergonomics	Civ	
PHE/Medical Category/Screening	1. Mil 2. Civ	
Immunization		
Policy	1. Mil 2. Civ	
R & D	Civ	
Delivery	Civ	
Program administration (records, etc.)	Civ	

Treatment 1. Civ 2. Mil

4. Health Promotion Civ

National Défense
Defence nationale

Chief Review Services

REVIEW OF CF MEDICAL SERVICES

October 1999

7055-42-2 (CRS)

Team Leader: Harry Hubley, Principal
Deputy Team Leader: Norm Black, Principal
Team Member: Marie Kenny, Analyst
Team Leader of the November 1999 CDS Sponsored Task Force: Colonel Lise Mathieu, EA/CDS

Canada

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EXECUTIVE SUMMARY

Background

1. In January 1999, at the request of the CDS, the Chief Review Services undertook a review of the provision of in-garrison medical services in the CF. The team was specifically tasked to examine the issues of *Continuity of Care* and the *Administration of Temporary Medical Categories,* as well as to examine other issues relating to the provision of care to CF members. The scope of this review has been restricted to in-garrison medical care delivered to Regular Force CF members and did not address medical matters relating to the Reserve Force, delivery of medical care in operations, or the delivery of dental services in the CF.

2. The Canadian Forces Medical Service (CFMS) has been on a journey of renewal and reengineering which began in 1990 when deficiencies in the operational deployability of its medical service were identified. Ten years later the CFMS can be characterized as a change-fatigued organization which has taken significant steps towards improving its operational focus while coping with downsizing, budget reductions and striving to maintain a high level of in-garrison care. The Op Phoenix reengineering exercise that began in 1994/95 was the principal architect of the restructured CFMS and provided the blue print to bring a greater operational focus to the medical services.

3. A basic premise of the Op Phoenix concept was to place greater reliance on the public sector health care systems to secure in-garrison medical care. However, concurrent with the downsizing and reengineering activity that was taking place in the CF, the civilian health care system was also experiencing a similar restructuring process. As a result, the CF was faced with the requirement to obtain many of its services from a system that was experiencing challenges of its own and under public scrutiny for the way it is delivering health care services.

Major Findings

4. Overarching Issues Impacting the Delivery of In-garrison Medical Care. There are two significant overarching issues impacting the delivery of in-garrison medical care. It was noted early in the review that significant regional differences exist across the country and hence, rather than taking a 'one size fits all' approach to addressing the in-garrison needs of CF members, corporate strategies need to be interpreted and tailored to meet local circumstances. As well, issues related to delivery of in-garrison medical services identified in the CFMS are closely interrelated and improvements in one functional area will have a ripple effect and alleviate other problems. Similarily, problems that are not attended to will worsen and possibly contribute to other problems.

5. Strategic Direction. The CFMS is currently operating without strategic direction. An impact of operating without that direction is high levels of staff frustration. As staffs are working hard for the organization, they are questioning how their efforts fit within an overall strategy for the Branch and how they can contribute to the accomplishment of goals that they are not aware of. As well, units in the field are looking for broad guidance to assist them in better managing their respective medical facilities.

6. Concept of Operations. While there is well-founded logic supporting the concept of operations for the CFMS, it is not yet working effectively for a range of reasons discussed throughout the report. Two of those reasons include a complex command and control structure without having internal mechanisms to ensure that it functions well, and the fact that the primary means of delivering in-garrison services was changed without ensuring that adequate mechanisms were in place to provide for the continuity of a comprehensive health care delivery system.

7. Standard of Care. Although excluded from provincial health care insurance plans, the Canada Health Act (1984) mandates that members of the CF receive the same level of health care services as all Canadians. Due to the reliance on the civilian health care sector for medical treatments and services that cannot be provided by in-garrison facilities, CF members receive a portion of their health care in the same manner as members of the public. Similarly, provincial licensure requirements for CF medical officers and extensive use of civilian physicians on contract to the CFMS ensure that professional standards are consistent with the public sector. The CFMS Spectrum of Health Care Document provides CF members with a range of medical services which are more comprehensive than the publicly funded provincial systems, while also providing for the unique aspects of CF occupational medicine along with other services such as over-the-counter medicines, therapy services etc. However, significant patient concerns exist in the areas of timeliness and access to medical services, regional inconsistencies in levels of service and the manner in which in-garrison care is being delivered as a result of a focus on operational responsibilities. CF members have expressed particular frustration with poor administration relating to the delivery of their in-garrison medical care.

8. Continuity of Care. Continuity of care is a significant concern of the CF leadership and CF members. The review team saw significant evidence to indicate that where continuity of care has been weak, patient care has been negatively impacted. The CF is pursuing strategies similar to their allied counterparts in attempting to strengthen continuity of care through increased civilianization. Evidence indicates that leadership must assume a more prominent role in this aspect of medical care than it has in the past.

9. Administration of Temporary Medical Categories. The concepts on which temporary medical categories (TMC)s are premised are sound. When they are injured, CF members need to have an opportunity to heal and not risk further injury to themselves or endanger other members of their units. When members are assigned TMCs they are not consistently well-attended to administratively and at times they are ostracized by their units. Leaders need to play an active role to ensure that members on TMCs are not mismanaged or inappropriately administered

within the system. While judgement is required in each individual case timely attention to matters related to TMCs is required in order that the needs of the patient and the CF are appropriately provided for.

10. CFMS Organizational and Command and Control Issues. This is a very complex area for the CFMS. The rationale to change from pre-Op Phoenix organization structures is sound as these earlier organizations that were structured to deliver in-garrison care proved not to work well when medical personnel were required for deployment. The structure that is in place today is responding to the requirement to fulfill operational needs, but is awkward, at times difficult to manage and not consistently supportive of the effective delivery of in-garrison medical care. Standing up the capability to secure contract physicians through the Designated Provider Plan and putting in place service level agreements between CF medical facilities and operational units, should ameliorate some of the difficulties being experienced. In order to carry out the mandate assigned to the CFMS through the Op Phoenix review, the existing command and control structure remains the most practical one at this time. However, consideration should be given in 18 to 24 months to establishing a centralized health services organization for the long term benefit of delivery of in-garrison care to CF members.

11. CFMS Resources, Establishment and Staffing. Making informed, objective judgements on the adequacy of the resourcing of the CFMS is difficult because of the current and prolonged high tempo of operations, unavailability of workload statistics since the discontinuance of that data gathering capability, significant numbers of unfilled billets and lack of an effective system for backfilling medical officers with civilian replacements. There is a preponderance of medical personnel with clinician skills performing management and administrative roles in the CFMS. At a time when certain clinician trades are operating short of establishment (medical officers and medical assistants) the resourcing question is broader than one of sufficiency, but extends to how appropriately and effectively the resources available are being applied.

12. Recruitment and Retention of Medical Officers. Staffing of medical officer positions is approaching critical levels (70 per cent vacancy forecasted by FY 2001) as recruitment of new general duty medical officers (GDMO)s into the Medical Officer Training Program (MOTP) is decreasing while the rate of attrition is rising (approaching 80 per cent attrition at the end of the obligatory period of service). The combination of these two trends is creating critical shortages of practicing MO clinicians. While the CFMS is pursuing strategies to increase recruitment, the effectiveness of which remain to be seen, little has been done to actively retain MOs. Recommendations in this report strive to address this problem.

13. Morale, Attitude and Capacity for Change. Morale in the CFMS is generally low. A significant factor contributing to low levels of morale is a widespread sentiment that the medical service is in a downward spiral, which is felt by clinicians and administrators alike and fed back to CFMS personnel during patient contacts. Attrition is high, particularly among MOs. Negative feedback reported in the media, government reports, and Standing Committee on National Defence and Veterans Affairs (SCONDVA) hearings has further contributed to a decrease in morale amongst CFMS staff. Highly stressed professionals and support staff,

wondering about the organization's strategic direction, fatigued by seemingly endless process changes and heavy workloads with little end in sight, are showing the strain through their attitude towards their work and patient care. While this group is left with little reserve capacity for change, further change is required. It will only be through significant assistance and support from the Branch, departmental leadership, and other sources that this group will be able to carry on to accomplish what remains to be done to address current deficiencies in the delivery of in-garrison care.

14. Administration of In-garrison Patient Care. CF patients closely associate the administration related to their care to the actual quality of care they are receiving. In many cases patients felt that they had been let down by the system's inability to staff in-garrison facilities with civilian doctors (continuity of care), physicians consumed with paper work during appointments rather than delivering care, patient records getting lost, incomplete files, lab test results going astray, and patient files not arriving in time for specialist consultations. Also, members attending civilian clinics when military medical facilities are not available are having to deal with administrative problems such as civilian clinics demanding cash payments for services rendered to CF patients. While some of these problems are being addressed by the CFMS, the review team offers recommendations and strategies to address others. Solutions being developed by the CFMS do not assure immediate fixes. Accordingly, in the interim, the patient continues to experience frustration and inconvenience with a consequent loss of trust and confidence in their medical system.

15. Migration of Ideas. The CFMS is comprised of a series of organizational and occupational stovepipes. These stovepipes interfere with the migration of ideas. The CFMS needs to take specific steps and actions in order to cross these boundaries and make sure good ideas and experiences with ideas that haven't worked so well, are shared within and across organizations. With high staff turnover, unfilled established positions and lack of depth in organizations due to staff reductions, there is no longer the opportunity for all CFMS personnel to learn by trial and error on their own. The regular sharing of ideas is critical to the future effectiveness of the CFMS. The sharing of ideas, knowledge, experiences and solutions to health care issues is critical within such a small cadre of health care professionals to ensure the ongoing effectiveness of the CFMS. It will be the responsibility of the leadership and senior management of the medical service to facilitate and encourage forums for the migration of ideas across the Branch.

16. Information Management and Information Technology. The CFMS does not yet have a centrally driven IM/IT system to support the delivery of in-garrison care. Similar systems are still in their infancy in the civilian sector with none known to be fully functional at this time. The CF has security implications to consider as it moves increasingly towards interfacing with the civilian sector. The *Migration of Ideas* concept offers the opportunity for sharing of interim IM/IT solutions that have been developed at the local level to bridge the gap between the present situation and the time that a corporate level CF IM/IT system is put in place.

17. New Initiatives. The CFMS, in cooperation with organizations within and outside the CF, is at various stages of implementing a range of new initiatives intended to better meet the service members' in-garrison medical needs. The CFMS and its various partners should be recognized for the important contributions that they are or will be making in these areas. From the perspective of improving the management of in-garrison care, the review team sees enormous potential for Staff Assistance Visits, under the direction of CFMG HQ, to identify potential site specific improvements and serve as a catalyst for the migration of ideas across CFMS MOCs and organizations. Other important initiatives identified in the report are:

- Designated Provider Plan - a mechanism to assist the member and health care providers to secure health information and medical services from the civilian sector;

- DND/Veterans Affairs Canada (VAC) Centre for the Support of Injured and Retired Members and their Families - a point of liaison to assist members in their transition from being cared for by the military to obtaining services from VAC and other organizations;

- CF 98 Report on Injuries and Immediate Death - measures being taken to ensure the completeness and availability of this form when members need to seek pension benefits related to medical problems;

- Canadian Forces Member Assistance Program (CFMAP) - a confidential program focused on assisting members who have been victims of harassment, sexual assault or sexual harassment to seek timely psychosocial assistance;

- Operational Behavioural Sciences Centres - 5 centres located across Canada where members with illnesses or normal reactions to abnormal situations can go to receive confidential assistance. Post traumatic stress disorder is an illness that is highly prevalent in the military today and will be treated at these centres; and

- Information Guide for CF Health Services - a single guide that provides a comprehensive information package to members to assist them in understanding their medical entitlements and advising how to access them.

18. Benchmarking. The CF medical service was benchmarked with those services provided by three allied countries - United Kingdom, New Zealand, and the United States. There is a general trend among militaries to extract themselves from the business of running hospitals and partner more with the civilian sector. Other countries are experiencing similar recruitment and retention problems of MOs as the CFMS. There are also differing strategies being pursued such as the US primary care manager concept for strengthening in-garrison care. Just as migration of ideas is important within DND/CF, the CFMS must also look to our allies to see if there are successful approaches being pursued by them which would be applicable in the Canadian context.

Overall Conclusions

19. The CFMS, staffed for the most part by highly skilled, fully competent, dedicated and committed military and civilian personnel, is a fatigued organization without clear strategic direction and perceived by some to be in a downward spiral. The CFMS has been downsized, restructured, reengineered, suffered high levels of attrition and turnover, and is experiencing consequent low levels of morale and diminished attitudes reflected in the service being offered to patients seeking in-garrison medical care. It is an organization with little reserve capacity for further change.

20. Recognizing that the CFMS has already been through dramatic changes in recent years, the review team has endeavored to offer meaningful and relevant recommendations, and an action plan which was developed by a special CDS Task Force has also been included in this report. The recommendations and action plan are intended to address correctable deficiencies and proposing more general strategies for approaching the issues where solutions are less clear. Making recommendations that would result in more radical outcomes, with potentially debatable benefits, could run the risk of negating some of the positive work done under Op Phoenix, and throwing an already stressed organization into further turmoil. The review team offers its suggestions and recommendations in the spirit of assisting the CFMS to make a strengthened contribution to the quality of life of CF members through its critical role of providing medical services.

PART 1 - INTRODUCTION

BACKGROUND

1.1 In January 1999, Chief Review Services (CRS) was tasked to conduct a review of the Canadian Forces Medical Service (CFMS) to address issues and concerns that had been brought to senior management attention[1]. While the CFMS has been the subject of numerous reviews over the years it has not been the subject of an independent assessment since the major renewal and restructuring exercise that began in 1994, known as Op Phoenix.

1.2 The 1977 S-42 CRS Study confirmed the rationale for the existence of the CFMS and this was reconfirmed in the 1993 CRS Program Evaluation of Medical and Dental Services - E1/92. There are several basic factors that were highlighted in these earlier CRS studies that provide sound rationale for the continued existence of a Canadian Forces Medical Service. While CF/DND and the medical service in particular have been through dramatic change in recent years, some basic factors remain immutable: "...Members of the CF serve with unlimited liability. That is, they must be prepared to make a total commitment, up to and including loss of their lives in the service of the nation. Commanders in turn are expected to ensure that military personnel resources will not be wasted and that everything feasible shall be done to provide for the care and survival of personnel under their command in both peace and war..." [2]

1.3 It is important to note that Op Phoenix marked a significant turning point for the CFMS as the renewed organization was premised on a more operationally-focussed medical service that would achieve its objectives with fewer uniformed medical personnel. It would also place a greater reliance on the civilian sector for the delivery of in-garrison care. The provision of a high standard of medical services to the CF in the post Op Phoenix environment is a critical component of the departmental Quality of Life initiative. It is an ongoing concern of the CF that quality medical care continues to be provided by the CFMS, recognizing that significant renewal changes have been experienced. Accordingly, it is in the context of the dramatic changes that have taken place recently in the CFMS that this CRS review is being undertaken.

[1] Meeting General Baril, Chief of the Defence Staff/Lieutenant-General Leach, Chief of the Land Staff/Major-General Couture, Acting Assistant Deputy Minister (Human Resources - Military)/Major-General Penney, Chief Review Services - 13 January 1999

[2] Chief Review Services/Director General Program Evaluation, NDHQ Program Evaluation E1/92 - Medical and Dental Services, November 1993, PP 31 -32

AIM AND SCOPE

1.4 The aim of this review is to provide senior departmental management with findings, analysis and recommendations regarding the effectiveness of the CFMS in providing in-garrison care to regular force members. In addition to a comprehensive review of issues which impact on the quality and delivery of CF in-garrison medical care, the CRS review team has been directed to address the concept of 'continuity of care in the CFMS' and the management and administration of 'temporary medical categories'.

1.5 The scope of this review has been limited to the provision of medical services in the in-garrison context. Provision of operational medical services to members in theatre or on deployments, specific reserve issues relating to medical care and the provision of dental care have been excluded from this review. It has been determined by the CRS team, however, over the course of the review that addressing the issues directly impacting on the delivery of medical care to regular force members has the potential to offer benefits to reserve force members as well.

ISSUE AREAS

1.6 In addition to the two issue areas that were clearly specified for the review team - *continuity of care* and *the administration of temporary medical categories*, there is a range of other sub-issues that impacts the quality and delivery of medical care to the CF. Some of these sub-issues that are discussed in this report include, but are not restricted to *Standards of Care Provided to CF Members, Organization and Command and Control, Human Resources* and *Information Management and Information Technology*.

METHODOLOGY

1.7 More than 70 interviews were conducted and analyzed at three bases and at Canadian Forces Support Unit Ottawa Health Care Centre (CFSU(O) HCC), National Defence Headquarters (NDHQ), RCMP, Health Canada and private sector health care providers. As well, 17 focus groups were conducted at six sites across the country including CFBs Halifax, Gagetown, Borden, Ottawa, Cold Lake, and Petawawa.

1.8 The review team consulted personnel in the medical services branches of the US Department of Defense, as well as the Ministries of Defence for the United Kingdom and New Zealand. This benchmarking information enabled the team to benefit from the knowledge of areas of similarity and difference when analyzing the DND/CF situation.

REPORT STRUCTURE

1.9 Part 2 presents a discussion and analysis of the issues that the team was specifically requested to explore and other subject areas that arose as the review progressed. Part 3 is a summary of concluding material including recommendations and solutions which suggest changes that would contribute to the effectiveness of the delivery medical services to the CF. Part 4 provides an action plan, developed by a CDS directed Task Force following the conduct of the CRS review, which will assist in prioritizing activities that will need to be undertaken in order to make needed improvements to the delivery of in-garrison patient care.

ACKNOWLEDGEMENTS

1.10 The Review Team gratefully acknowledges the cooperation and assistance that was received from all personnel consulted within DND and the CF, as well as those organizations which submitted research and documentation contributing to the benchmarking of primary medical care provided to service members. The Team would specifically like to recognize the contribution of those CF members who willingly and frankly shared their views and experiences on the subject of this review during the CRS interview and focus group sessions.

PART 2 - ISSUE DISCUSSION

OVERARCHING ISSUES IMPACTING THE DELIVERY OF IN-GARRISON MEDICAL CARE

2.1 During the conduct of this review the team observed that there were three overarching issues or themes that should be stated at the outset which contribute to understanding why the CFMS functions as it does and how it has evolved over time. These overarching issues are discussed in the following three paragraphs.

Regional Differences

2.2 While there are many challenges facing the CFMS that are systemic in nature and impact the CF equally among regions across the country, regional differences do exist. The consequence is that a 'one size fits all' solution or approach is not always appropriate. Recognition of these differences supports tailoring the application of corporate direction and policy at the local level to best meet the needs of the CF and DND.

Interrelationships Between Issue Areas

2.3 Many of the challenges facing the CFMS are interrelated and interdependent. As a result, the impact of solutions is not limited to addressing one issue, but will frequently contribute to improvements in several areas. When one problem is fixed, it has a multiplier effect throughout the organization. Similarly, leaving some problems unresolved has a ripple effect, of either exacerbating existing problems or creating new ones. Accordingly, when drawing conclusions and proposing recommendations, the review team directed its attention to those areas that offered the opportunity to have the greatest positive impact on delivery of in-garrison medical care to the service member and were within a 'sphere of influence' of the management and leadership of the CF and the CFMS.

Approach to Implementing Op Phoenix

2.4 The major impact of Op Phoenix on the CFMS's ability to deliver quality in-garrison health care stems from the implementation action that was taken on the Op Phoenix recommendations. The Op Phoenix Strategic Plan was approved in principle by Armed Forces Council in June 1995. A team was established under the Canadian Forces Health Services Renewal Project (CFHSRP) to implement the restructure of the CFMS and CFDS. Early in the process, it was realized that an approved Master Implementation Plan was required to restructure the CFMS as the changes impacted on all areas of the CF.

2.5 During 1996 a Master Implementation Plan (MIP) was developed for the re-engineering of the CF Medical and Dental Services. This plan was developed in consultation with the various Capability Component (CC) stakeholders. While ECSs and other senior leaders/ managers were briefed on the final implementation plan it was never signed-off. Without official departmental approval of the MIP, the door was open to selective implementation of parts of the Op Phoenix concept without clear corporate direction.

LEGAL BASIS AND MANDATE FOR THE CFMS

Legal Basis for the Canadian Forces Medical Service

2.6 As reported in earlier program evaluation work on the provision of medical care to CF members[3], Judge Advocate General (JAG) staff have determined that there are three principle pieces of legislation that place responsibility on the Federal Government to provide medical care to members of the Canadian Forces. The first piece of legislation, the Constitution Act of 1867, specifies that matters related to defence (health care provided to CF members is one such matter) fall within the jurisdiction of the Federal Government. The second, the National Defence Act, authorizes the governor-in-council and MND to provide for the organization, efficiency, administration and good government of the CF which would include the provision of medical care to CF members. Q R & O 34.07 -Entitlement to Medical Care is such a regulation.

2.7 The third piece of legislation that indirectly places a further legal obligation on the CF to provide medical care to CF members is the Canada Health Act (1984). This Act exempts CF members from the list of 'insured persons' for whom health services are provided under provincial health care insurance plans. While CF members are excluded by the Act from deriving benefit from provincial medical insurance coverage, as Canadian citizens, they too as a matter of policy and military efficiency should have their health *protected*, *promoted* and *restored* in accordance with the stated principles of Canadian health care policy as enunciated in Section 3 of the Canada Health Act. It is by virtue of these pieces of legislation that the CF has legal responsibility to ensure medical care is provided to its members.

Mandate of the Canadian Forces Medical Service

2.8 The responsibility for the CF to provide a military medical service is implicit in the exclusion of military personnel from coverage under provincial health care plans as specified in the Canada Health Act 1984. Therefore, the CF might have as its objective the provision of medical service to its members more or less comparable to that available to Canadians generally under provincial medical plans. Toward this end, the CDS has issued QR&O 34 which directs that medical services be provided to CF members and furnishes the CFMS with its mandate. [4]

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[3] Chief Review Services/Director General Program Evaluation, NDHQ Program Evaluation E1/92 - Medical and Dental Services, November 1993, PP 31 -32

[4] Queens Regulations and Orders, Chapter 34- Medical Services, undated, 34.07 - Entitlement to Medical Care "…..In Canada, medical care authorized in this article shall be provided: …(a) in a medical facility operated by the

2.9 The role of a medical service in the CF has historically been to conserve manpower and ensure that its members are healthy and returned to duty as soon as possible after they become ill or wounded. It is acknowledged that members of the CF serve with 'unlimited liability'. In turn, it is the responsibility of the chain of command to ensure that military personnel will not be wasted and that everything feasible will be done to provide for the care and survival of the personnel under their command in both peace and war. This responsibility has been reiterated by the CDS[5] through the following statement:

> "Whether in Canada or abroad, military service is an inherently dangerous way of life. In return for their commitment and unlimited liability to serve, our sailors, soldiers and air personnel rightfully expect the best medical care and attention possible."

It is therefore implicit that the mandate of the CFMS is to ensure that CF personnel are provided with comprehensive, high quality medical care comparable to that available to all Canadians under provincial health care plans both in peacetime, and in wartime.

STRATEGIC DIRECTION FOR THE CFMS

2.10 During field visits across Canada and at NDHQ, a recurring theme that emerged was a need for strategic direction to guide the delivery of in-garrison medical care in the CF. Health Care Coordinators (HCCs) represented one group in particular that was looking for guidance regarding the scope of activities that should be provided in their in-garrison clinics. Without this guidance some HCCs were unclear in setting bounds or parameters on the nature and type of medical procedures that would be performed in their facilities and appropriately applying resources under their direction. While HCCs knew that the intent of the Surgeon General was to strive to provide a uniform level of in-garrison medical care nationally, achievement of this objective was found to be difficult without overarching strategic direction.

2.11 The need for strategic direction is not restricted to HCCs, but was conveyed by a wide range of CFMS groups. Within CFMG HQ itself, staffs reported having to deal with a steady stream of daily crises, some of which will continue to come regardless of the existence of strategic direction, but suggested that they could be dealt with more consistently with appropriate strategic direction for the Branch. As was expressed to the review team on a number of occasions throughout the review - the CFMS can't be operationally relevant, maintain a high standard of in-garrison care and cost less at the same time as health care budgets have been

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Canadian Forces or, where authorized.....in a medical facility operated by another department of the federal government or a civilian medical facility; and (b) by a medical officer of the Canadian Forces, ...by a medical doctor employed by another department of the federal government, a civilian medical doctor or such other health care personnel as may be authorized by the Chief of the Defence Staff."
(Similar paragraphs are included in the QR&O for Emergency Care and Medical Care in Foreign Countries)

[5] CANFORGEN 065/99 CDS 054, 29 July 1999

reduced in provinces and territories with some groups of health care professionals being in short supply in Canada. The CFMS can't be all things to all people, but rather needs a focus in order to know where to place the emphasis.

2.12 As a military medical service, the CFMS is not alone in feeling the need for strategic direction. As the British Ministry of Defence noted in the introduction to its strategic direction document[6]

> "...A common criticism made by defence medical personnel over the last few years is that they have no vision of the future for their Service. Lack of vision has bred uncertainty which has inevitably had a damaging effect on morale. The starting point for this booklet is therefore to set out a new vision for the DMS...The remainder of the booklet will explain how the vision will be achieved..."

2.13 Until recently, the Department and the CF did not have a corporate document that staffs could turn to in order to obtain strategic direction. Under the signatures of the Chief of the Defence Staff (CDS) and the Deputy Minister (DM) Strategy 2020 was issued in July 1999, which has set a strategic course for the Department and the CF. When Group Principals and equivalents now strive to provide strategic guidance to their respective staffs, there is a framework that provides parameters and a context for assessment of approaches that can be taken by their respective organizations.

2.14 Strategy 2020 now provides the departmental/CF strategic guidance framework within which organizations such as health services can develop a way ahead. As well, senior leaders responsible for delivery of medical services (ADM(HR-Mil) and the DGHS/Surgeon General) have the benefit of being able to draw on the recent first hand experience of the team that drafted Strategy 2020, as they consider various methodologies and approaches for developing a strategy for their function.

2.15 Just as was experienced in striking Strategy 2020, determining strategic direction for the CFMS will not be as simple as merely turning to DM/CDS and ADM(HR-Mil) and asking 'What are your expectations for the Canadian Forces Medical Services?'. Instead, putting in place meaningful direction will require adoption of an iterative process that engages senior leaders and other key stakeholders. The exercise will need to be well-communicated throughout the branch, and feedback and ideas broadly solicited.

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[6] Ministry of Defence, United Kingdom, http://www.mod.uk/policy/medical/intro.htm, Defence Medical Services: *A Strategy for the Future*, 1998

Conclusions Related to Strategic Direction

2.16 The review team has concluded that:

a. providers of health care services within the CFMS do not feel there is a clearly articulated strategic direction for the provision of medical services in the CF;

b. lack of strategic direction has left a change-fatigued CFMS wondering what the long term plan for the organization is and what are its strategic priorities for getting there;

c. development of strategic direction requires a thoughtful, interactive, iterative process that fully engages those who are clients, stakeholders and deliverers of the program; and

d. CFMS staff need to know that this process is in train, that they will have an opportunity to contribute to the plan and that there will be comprehensive communications on the outcome of strategic direction for the Branch.

Recommendations Related to Strategic Direction

2.17 The review team recommends that:

a. steps be taken without delay to put in place a process to develop strategic direction for the CFMS Branch;

b. a communication strategy be developed to inform all members of the CFMS of the objectives and process related to formulation of 'Strategic Direction'; and

c. the casting 'Strategic Direction' be an exercise that is inclusive of all aspects of Health Services and not be restricted to medical services.

CONCEPT OF OPERATIONS AND THE IMPACT OF OP PHOENIX ON IN-GARRISON CARE

Background to the Concept of Operations for In-garrison Care

2.18 The concept of operations for the delivery of in-garrison medical care has evolved in recent years and continues to do so. While there has been a range of studies pertaining to the CFMS over the years, as noted in Part 1, there are four events/studies in particular in the recent history of the Branch that have had significant impacts on the concept of operations for delivery of in-garrison medical care.

2.19 The chain of events that has occurred since the beginning of this decade that provide the impetus for dramatic change in the CFMS began with the Office of the Auditor General (OAG) Report in 1990. Among other things, the Report stated that:

> "...The medical support system was not designed to meet wartime requirements. It has evolved to meet primarily peacetime needs. Current deficiencies call into question the Canadian Force's ability to provide a complete and continuous system of medical support in time of war..."[7]

The publication of the results of this audit was a defining moment for the CFMS in that an external independent review organization formally challenged the CF's ability to medically respond to operational demands.

2.20 A second significant event that occurred was the CRS Evaluation of Medical and Dental Services in 1992.[8] During interviews conducted in support of that effort, CFMS staffs consistently confirmed the accuracy of the 1990 OAG message and acknowledged that the shift to a more operationally focused medical service had not yet occurred. While the importance of in-garrison and operational medical care were both acknowledged, the primacy of operational care was captured in the following quotation from an Associate Assistant Deputy Minister (Personnel) staff document[9].

> "...The role of the CFMS is to ensure that CF personnel are healthy, medically fit for duty, and provided with timely and effective medical care in both peace and war. First and foremost the medical service must be able to support an operationally deployed force (s) on short notice anywhere in the world and provide up to Level Three (emergency life-saving surgery) medical care; treatment must be appropriate and timely; and patients must be returned to duty expeditiously. In addition it must provide the health readiness of the forces..."

2.21 Beginning in 1989 was a series of budget cuts which would not stop until fiscal year 1998/99. After absorbing its share of cuts for six years, yet only marginally changing the way it did business, it was recognized that the method of delivery of CF health services (medical and dental) had to change significantly in order to continue to function effectively in a fiscally constrained environment. Accordingly, in 1994, it was determined that the CFMS would constitute a team known as Op Phoenix, to reengineer medical services in the CF.

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[7] 1990 Report of the Auditor General of Canada, DND Human Resource Management - Medical Support, 1990

[8] Chief Review Services/Director General Program Evaluation, NDHQ Program Evaluation E!/92 - Medical and Dental Services, November 1993

[9] Director Civilian Human Resource Management, Discussion Paper: Rationalization of Canadian Forces Medical Services Minimum Manpower Requirement, 9 November 1992

2.22 As highlighted in earlier paragraphs of this Part of the report, the Master Implementation Plan (MIP) did not receive departmental sign-off. Accordingly, while formal senior leadership acknowledgement and approval of CFMS' renewal strategy was secured in 1995[10], regrettably for the CFMS and its leadership, what was not obtained was approval of the MIP or roadmap that would secure a mandate for full implementation. This gap in the approval process has resulted in a fragmented approach to implementation of Op Phoenix. It is, in part, the partial implementation of the Op Phoenix concept that has resulted in in-garrison care being delivered as it is today.

Concept of Operations for In-garrison Care

2.23 One of the major Op Phoenix objectives was to structure the CFMS military personnel into units to support CF operations, and to utilize these resources to provide in-garrison health care only on an as available basis. Through implementation of the Op Phoenix concept it was also expected that the various uniformed medical occupations would maintain their clinical and professional skills in clinical settings in the civilian sector (maintenance of competency through embedding arrangements in civilian hospitals) and in more structured educational settings (continuing medical education). A small management component was established at each major CF base to coordinate in-garrison health care delivery. In-garrison health care was to be provided by utilizing a combination of CF operational health care personnel assigned to the respective bases and by using civilian resources to provide the required services either at the base facility or at civilian locations in the local area.

2.24 With operational primacy as the driving factor, the bulk of medical personnel belong to CFMG and environmental chiefs of staff (ECS') rather than authorities directly responsible for the delivery of in-garrison patient care. CFMG resources support deployment of 1 Canadian Field Hospital and advanced surgical units. As well, Environmental Chiefs have medical personnel resources to staff the brigade field ambulances, air field medical units, unit medical personnel in support of battalions, airframes and personnel to support medevacs, and ship-borne medical services.

2.25 The strong emphasis on operations and consequent dedication of resources to that effort leaves minimal numbers of CFMS personnel to support in-garrison care. In-garrison care is delivered largely through the base/wing Health Care Centres staffed by Health Care Coordinators (medical officers) supported by a health care administrator. These resources are on the base/wing establishment under the command and control of the Base Commander. Health Care Centres are also supported by civilian contract doctors, working full or part time depending on local arrangements. Medical officers, specialists, nurses, and medical assistants are normally CFMG or field ambulance personnel on loan to Health Care Centres when not on deployment, training or otherwise engaged in primary operations-related activities.

[10] Armed Forces Council, Op Phoenix - Reengineering of the CFMS, June 1995

2.26 In the Army, unit medical officers (UMO) and medical assistants (Med A) provide in-garrison care to units when they are in-garrison. When the unit is deployed the UMOs and Med As deploy with the unit and those who aren't deployed obtain their in-garrison care from the field ambulances or the base/wing Health Care Centre.

2.27 While not explicitly stated in doctrine or policy, Medical care in the CF is premised on the principle of a continuum. From the CF's perspective the main components of health care that must be provided for are: health promotion, prevention (public health), occupational health, restoration; and deployable medical support. While some components are provided for primarily through *in-garrison care* and others are more closely associated with *operations*, there is some overlap. Putting it more simply, one interviewee described in-garrison care as 'prepare them and repair them' and medical care in support of operations is that which is delivered in theatre. The fundamental point here is that in-garrison and operational care are intended to be working as a seamless continuum, neither working completely independently of the other. The objective of the continuum is that whether at home or abroad, CF members receive medical care that is at least equal to the care to which all Canadians are entitled.

Impact of Op Phoenix on In-garrison Care

2.28 Stated very simply, the impact to date of Op Phoenix on delivery of in-garrison care has been both positive and negative. The positive results have been:

a. the issuance of the CF Spectrum of Care document[11] which describes the health care benefits and services, medical and dental, that are available and publicly funded for members of the CF and other eligible persons;

b. in response to 1990 OAG observations[12] related to inefficiencies of military hospitals in comparison to their civilian counterparts, all but one of the CF accredited hospital have been closed or reduced to clinics/health care centres and services are being obtained from, or embedding arrangements have been made with civilian hospitals;

c. implementation of some of the Op Phoenix concepts has exposed gaps that need to be closed in order to assure an appropriate level of in-garrison medical care for CF members; and

[11] Office of the Commander of the Canadian Forces Medical Group/Surgeon General of the Canadian Forces, The Canadian Forces Spectrum of Care, December 1998

[12] 1990 Report of the Auditor General of Canada, DND Human Resource Management - Medical Support, paras 23.22 to 23.29, 1990

d. the Designated Provider Plan (DPP) MOU between DND and VAC, primarily for claims processing, was approved by ADM (HR-Mil) in June 1999. Obtaining sign-off of this document begins a process intended to significantly improve delivery of in-garrison care, primarily through greater access to the civilian sector.

2.29 The more negative aspects and impacts that relate to the Op Phoenix implementation are highlighted below:

a. while the Op Phoenix Strategic Plan was approved in principle by Armed Forces Council in June 1995, the follow-on Master Implementation Plan (MIP) did not receive departmental sign-off. Without a senior management endorsed MIP (tactical direction to make Op Phoenix a reality), considerable latitude was implicitly granted to the CFMS in terms of how and what should be implemented. The result has been a prolonged, partial implementation approach that has placed considerable pressures on CFMS staff and in turn has impacted on delivery of in-garrison patient care;

b. certain fundamental assumptions underpinning Op Phoenix proved to be inaccurate, due in part to unforeseen changes in the civilian sector. The following is a partial listing of some of these circumstances:

(1) costs of accessing the civilian sector proved to be higher than expected as it was not anticipated that the CF would be charged the highest rates when accessing provincial health care systems,

(2) dramatic cuts to provincial health care budgets were not anticipated and the influx of CF members demanding services from the civilian sector has added to already increasing patient per doctor ratios across the country, and

(3) IM/IT tools were expected to be in place to support management of patient information across the CF. To date no corporate systems have been developed to support this IM challenge[13];

c. the morale of a 'change-fatigued' cadre of CFMS personnel has been significantly eroded as the group enters its 5th year of implementation of the Op Phoenix concept designed to address issues first identified almost 10 years ago[14];

d. health care coordinators (formerly base surgeons) are unclear on their respective roles and are looking for guidance on the scope and range of services that they are expected to provide at health care centres/base clinics; and

[13] a more complete discussion of IM/IT is provided later in Part 11 of the report.
[14] Report of the Auditor General of Canada, DND Human Resource Management - Medical Support, 1990

e. anecdotal evidence provided to the CRS team indicates that health care centres/base clinics may be understaffed or inappropriately staffed. The clinics have become dependent upon CFMG/field ambulance staff when they are available and when these resources are withdrawn to perform their primary roles health care centres/base clinics are not always able to backfill. Funding shortfalls or unavailability of civilian medical professionals are the most frequently cited reasons.

Conclusions Related to the Impact of Op Phoenix on In-garrison Care

2.30 The review team has concluded that:

a. implementation of Op Phoenix has had both positive and negative impacts;

b. from a positive perspective, putting in place aspects of Op Phoenix, such as accessing services from the civilian sector, has educated the CFMS on challenges that may not have been fully appreciated at the planning phases of the reengineering effort; and

c. on a more negative note, there has been a partial and fragmented approach to implementation of the Op Phoenix concepts. The process, which has been extended over a prolonged period of time, and is not yet complete, has been very difficult for medical service providers and their clients to the point that issues of morale and trust are surfacing in significant ways. The result has been an erosive effect in these areas from which the review team believes it will take the CFMS considerable time to recover.

STANDARD OF CARE PROVIDED TO CF MEMBERS

2.31 The Canada Health Act (1984) mandates that Canadian Forces members are entitled to the same level of health care as all Canadians. In addition to this basic entitlement, the CDS has acknowledged the health care responsibilities of the CF in a recent CANFORGEN[15]:

> "...military service is an inherently dangerous way of life. In return for their commitment and unlimited liability to serve, our sailors, soldiers and air personnel **rightfully** expect the best medical attention possible. The health and safety of our personnel remains our foremost concern."

[15] 29 July 1999 CANFORGEN. Special message from the CDS.

2.32 The Canada Health Act, as noted earlier, also specifically excludes members of the CF from provincial health insurance plans by stating that "an insured person" means "...a resident of the province *other than a member of the Canadian Forces*." Therefore, by means other than provincial health insurance plans, the CF provides its members with comprehensive and competent medical services comparable to those provided to Canadians generally.

2.33 Prior to the OP Phoenix reengineering review of the CFMS, the DGPE program evaluation of 1993 noted that Commanders and staff alike shared a high opinion of the quality of available in-garrison care. The general consensus at that time was that there was:

> "...considerable confidence that the CFMS provides an excellent standard of day-to-day care ...(and) that the medical needs of the staff will be attended to promptly and effectively by the CFMS regardless of the cost of the treatment."[16]

During the conduct of this review, the question was posed whether the current level of in-garrison health care received by CF members was comparable to that available to other citizens of Canada. While there are no definitive performance standards or objective criteria to answer this question, a discussion of focus group responses, benchmarking with other military organizations and a synthesis of issues raised during this review, will provide an indication of the perceptions held regarding the comparability of health care provided to CF members in the post-Op Phoenix environment.

2.34 Focus Group Responses. The Review Team conducted seventeen focus group sessions where responses were solicited on a variety of issues from a CF population stratified along the lines of medical staff, CF patients (all ranks), and military commanding officers and supervisors. Views were sought on the comparability of in-garrison health care provided by the CFMS to that available to all Canadians. When asked to rate the overall quality of the care provided by the CFMS, 81 per cent of the medical professionals rated it as acceptable or better and 50 per cent rated the quality as very good to excellent. When asked to compare the in-garrison care to provincial health care provided to other Canadians, 92 per cent of the medical staff rated the level of care as the same or better. By comparison, 70 per cent of the CF patient population rated the quality of in-garrison medical care as 'adequate to excellent', and all commanding officers and supervisors described the quality of medical care provided to the CF by the CFMS as acceptable or better. When asked how the level of CFMS medical care compared to provincial coverage provided to other Canadians, 80 per cent of COs and supervisors rated it as the same or better. CF patients indicated that 62 per cent were satisfied with receiving their medical care through the CFMS while the balance would prefer to receive their medical care from civilian physicians through the provincial health care system.

2.35 Despite these generally favorable perceptions, there are significant areas where there are feelings of dissatisfaction with the provision of in-garrison care. Sixty-nine percent of CFMS medical staff felt they could provide a better level of care if they were not functioning within the

[16] Final Report on NDHQ Program Evaluation E1/92 Medical and Dental Services, Nov 93.

constraints of the CF medical system, and 64 per cent of medical personnel felt that the standard of care being received by CF members fell short or considerably short of meeting the needs of the member. In fact, 62 per cent of CFMS medical staff felt they were only somewhat clear to 'not at all clear' regarding the level or standard of medical care they are expected to provide to CF members in the in-garrison setting. Fifty-five percent of CF patients felt their interaction with the CFMS did not meet their expectations, although 78 per cent expressed full confidence in receiving their in-garrison care from the civilian physicians contracted to provide in-garrison care.

2.36 The most significant shortfall reported in the provision of in-garrison care is the timeliness of delivery of health care provided to CF members.[17] While this is a perception issue, it does reflect how members of the CF view the standard of care which they are provided. Sixty percent of CFMS medical staff expressed the view that the timeliness of the delivery of medical services to CF members fell "somewhat short or considerably short of meeting the needs of CF members to the extent that patients are at risk". A similar percentage was reported by Commanding Officers and supervisors regarding the timeliness of services available, while 75 per cent of the patient population that was surveyed reported that treatment received from the CFMS was not very timely or delayed for an unacceptable length of time. While the common perception exists that rapid access to health services equates to good health care and that a longer wait equates to bad health care, performance data does not exist which differentiates between the timeliness of health care provided by the CFMS and provincial systems, or between various regions of the country.

2.37 Regional variations in provision of health care. The Canada Health Act, while excluding CF members from provincial health plans, acknowledges 13 different health care systems, one in each province and territory. The CFMS, in effect becomes the 14th health care system in Canada with patients from coast to coast and abroad. CF personnel are located throughout Canada in every provincial jurisdiction while having an expectation of one consistent standard of health care no matter where they are posted. Prior to Op Phoenix, the CF had a resource rich medical system including three active hospitals offering a broad range of specialist and sub-specialist services. These facilities provided a high level of service, principally by uniformed medical personnel, and provided the capability to make up for inconsistencies between various provincial medical standards. These facilities no longer exist, and services that are no longer provided directly by the CFMS must be purchased from the civilian sector. In rural areas distant from major centres or sophisticated medical facilities, there is a critical shortage of some specialist medical services. It is in these areas where a large number of CF members are stationed. With reductions to the CFMS medical infrastructure and resources, there is a greater need to interface and rely on the civilian health care system which is characterized by regional variations in availability of services. While prior to Op Phoenix, the CF population developed expectations of a level of service based on a comprehensive in-house infrastructure staffed by uniformed medical

[17] The second most significant shortfall of the CFMS was the administration aspects of delivery of care. This issue will be discussed separately at para 2.200 of the report under Human Resource Issues – Administrative procedures.

personnel, this capability no longer exists. As a result, CF perceptions and expectations of timeliness and access to medical care based on pre-Op Phoenix facilities and resourcing, are no longer accommodated by the realities of locally available civilian health care facilities.

2.38 CFMS Spectrum of Health Care. Variations in the provision of provincial health care services available to the CF member are mitigated by the CF Spectrum of Care document which has been published and made available on the departmental Intranet. The Spectrum of Care document outlines all medical services and procedures that are provided at public expense to the CF member, as well as identifying those services/procedures which are not publicly funded. The document outlines a range of medical services that is significantly more comprehensive than any of the publicly funded provincial systems, and includes those unique aspects of CF occupational medicine which are generally only covered under third party medical plans in the civilian sector. These third party medical plans usually include some form of co-payment for services not covered under provincial plans. In addition, the CF Spectrum of Care includes over-the-counter medications, chiropractic services, physical therapy services, orthotics, braces and psychotherapy without limitations or restrictions.

2.39 Chain of Command. One factor which influences the standard of medical care provided to CF members is the Command and Control structure of the CFMS. Resulting from OP Phoenix, the CFMS has an operational focus, with Environmental Commanders responsible for the health of their troops. In-garrison health care and the provision of primary care, which is managed by the health care coordinator, is the responsibility of the Base Commander and follows that chain of command. While DGHS (which has been subsumed into CFMG) sets medical policy and standards and is responsible for paying for services purchased from the civilian sector, variations in the CF health care delivery system, allocation of local resources, setting of priorities etc. can all be influenced by local commanders. This in turn, influences the perceived consistency of quality of service delivered and has the potential to introduce differing levels of service at CF locations across the country. There is further discussion of the implications of command and control issues related to delivery of in-garrison care later in Part 2 of the report in the **Organization and Command and Control Issues** section.

2.40 Professional Standards and Qualifications. As discussed in the **Concept of Operations for In-garrison Care** section of the report, delivery of in-garrison medical services post-OP Phoenix is premised on a significant reliance on civilian physicians either on contract to the CFMS or by arrangements made with local service providers through the pending Designated Provider Plan (DPP). Focus group responses indicate that 78 per cent of the CF patients expressed a high level of confidence in the civilian physicians under contract to the CFMS to address their medical requirements, and similarly felt they were fully qualified to provide care that they required. All civilian physicians, as are all CF GDMOs, are licensed and trained by the appropriate provincial medical bodies, and provide medical services and procedures as directed by those organizations. As a result, the training and professional qualifications of the medical professionals providing in-garrison care do not, and cannot, differ from the standards governing the practice of medicine for all Canadians. However, it must be acknowledged that the majority of the general duty medical officers practicing medicine in the CF are relatively junior clinicians,

as those with 4-5 years experience are usually promoted into administrative positions or choose to leave the military. Similarly, a large cadre of experienced nurses were lost to the CF through the FRP, leaving a shortage of experienced nursing staff capable of providing supervision and guidance over clinical services. As a result, with the absence of clinical supervisors, experienced clinicians or an established audit capability to monitor the standard and practice of in-garrison health care, there is no assurance that the day-to-day in-garrison health care provided to CF members is comparable to that delivered in the civilian sector.

2.41 QR&O 34 issued by the CDS, provides the mandate to the CFMS to provide health care to members of the CF. The QR&O provides for the utilization of medical assistants in providing medical services to CF members under the supervision of a medical officer or physician. In the past, this has leveraged the use of limited medical resources and provided training and experience for the medical assistants. However, under the principles of the Canada Health Act, all Canadians are entitled to the services of a physician in the treatment of their medical complaint, and this principle is being more closely adhered to within the CFMS in the provision of in-garrison care. While following this principle in-garrison has curtailed some of the autonomy previously experienced and enjoyed by the medical assistants, it ensures that CF patients will receive the same access to treatment and diagnoses that patients receive in the civilian sector. This practice also adds to the workload of health care centre physicians, reduces responsiveness and patient access to treatment, while assuring that service for the patient is provided by a qualified physician. [18]

2.42 Benchmarking Standard of Health Care. When benchmarking the standard of care provided by the CFMS to that provided by allied forces, such as the NZDF Health Services, the UK Defence Medical Service or the US DoD Medical Services (Annex B), it is important to note that all have restructured their in-garrison medical services to rely on the public/private health care sector for much of their primary and secondary care. The US DoD medical service has introduced the TRICARE managed health care program which supplements military resources with a network of civilian health care professionals to provide access to medical services while preserving the capability to support military operations. A 1997 survey of the DoD TRICARE system[19] reported a 57.1 per cent personal satisfaction rating with the health care received at military facilities, while 70.9 per cent reported they were satisfied with the overall military health care system. Similar ratings were reported to the CRS review team through the computerized polling conducted during the CRS study focus groups, for overall satisfaction, but only 44 per cent of CF patients were personally satisfied with the treatment received.

[18] QR&O 34 states, in part that:
"In Canada, medical care authorized by this article shall be provided by a medical officer of the Canadian Forces or, ...by a medical doctor employed by another department of the federal government, a civilian doctor or such other health care personnel as may be authorized by the Chief of the Defence Staff."
[19] Trends Among Active Duty Military Responding to Health Care Surveys of DoD Beneficiaries – Fiscal Years 1995-1997, Defence Manpower Data Centre.

2.43 The UK Defence Medical Service is currently being centralized under the Surgeon General in order to improve on its in-garrison care which is characterized as "…currently fragmented and uneven in its quality and quantity…"[20]. As evidenced from this quote, the UK has been experiencing similar challenges to those faced by Canada, in the delivery of in-garrison care and was sufficiently concerned that they moved to restructure centrally as a means of improvement.

Conclusions Related to the Standard of Care Provided to CF Members

2.44 The review team has concluded that:

a. the CFMS, through its enabling documentation (QR&Os) and Spectrum of Care publication, has the authority to provide health care services which, at a minimum, are comparable to those offered under provincial health care plans;

b. in areas relevant to the occupational aspects of the CF, the comprehensiveness of medical coverage actually exceeds that provided to "insured Canadians";

c. focus group and interviewee responses acknowledge this coverage, but indicate that the CFMS falls short in the delivery of this capability due to administrative burdens, the perceived decline in service levels due to delays imposed by interfacing with provincial health systems, and customer service levels offered by the CFMS; and

d. from a medical skills, health treatment and spectrum of care perspective, the CFMS is comparable to provincial health care services available to all Canadians. However, the manner in which these services are delivered to the CF member appears to fall short of the civilian health care sector. As determined by the Review Team through interviews and focus groups, CF medical personnel have collectively admitted to a low level of morale coupled with a lack of professional challenge, which has contributed to an approach to their work reflected in patient care and the patients' perception of the care they are receiving.

[20] Brigadier L.P. Lillywhite, Director of Medical Personnel, Training and Policy, Surgeon General's Department, Ministry of Defence.

Recommendations Related to the Standard of Care Provided to CF Members

2.45 The review team recommends that:

a. CFMS professional medical staff be given clear direction on the level of medical care that they are expected to provide in-garrison. This would include a statement on the scope and range of services that are to be provided;

b. process re-engineering be conducted at the Health Care Centre/Base Clinic-level to evaluate current administrative procedures and, where they are lacking, make necessary adjustments to improve customer service at all in-garrison clinical settings;

c. an option for trans-regional accessibility to civilian health care treatment be made available to CF patients in order to align operational and medical priorities with optimal availability of care to reduce access delays. Judgements on making trans-regional treatment available to members should be made on a case by case basis[21];

d. appoint an external organization to conduct independent audits of CF health care facilities (in addition to the Staff Assistance Visits (SAVs) conducted by CFMG/DGHS staff) to measure and benchmark delivery standards; and

e. consideration be given to seeking provincial certification/accreditation of CF health care facilities from the Canadian Council on Health Service Accreditation to assure CF patients of comparable care to that which is available through provincial/civilian sector facilities.

CONTINUITY OF CARE

Background on Continuity of Medical Care

2.46 CF senior leadership concerns about the issue of 'Continuity of Care' was a significant driver behind the decision for this review to be undertaken. Information resulting from the conduct of interviews and focus groups, examinations of boards of inquiry and summary investigations and analysis of other background work to recent studies[22], sent the review team a clear message that continuity of medical care has been and remains an important concern in the CF.

[21] Trans-regional treatment is discussed more fully later in Part II of the report under **Securing Specialist Services for Delivery of In-garrison Care**

[22] CDS sponsored study, "Care of Injured Personnel and their Families Review", 1997

2.47 While individual interviewees generally had an image in their minds of what continuity of care meant to them, and were often able to articulate it very clearly, there was obviously not a generally accepted definition of what was meant by the term. While presenting at a meeting of the Special Committee on National Defence and Veterans Affairs in 1998 General Baril, CDS, offered his strategic thoughts on continuity of care when he said "....We must provide all sick and injured personnel with consistent and comprehensive medical support programs that provide continuity of medical care while serving, after release and during retirement...."

2.48 In subsequent discussions with the review team, CDS amplified on this thought by expressing the concern that procedures, checks and balances be in place to ensure that CF personnel receive consistent high quality medical care while in the CF, and that appropriate liaison/hand-off procedures are in place for a seamless transition as the members' medical care ceases to be a CF responsibility and falls under the jurisdiction of other organizations or systems.

2.49 Others expressed more narrow views of continuity of care being the development of a long term doctor/patient relationship that is a fundamental concept to the practice of family medicine. As a senior CFMG staff officer so clearly stated when briefing on the way in which medicine is practiced in the CF "...We have never been and never will be in the family medicine business as long as we are structured the way we are..."[23] Many interviewees reinforced this view recognizing the difficulties of establishing doctor/patient relationships and maintaining the consistency of such interaction when both parties were so mobile. Returning to the principles of the Canada Health Act of 1984, however, members also highlighted their entitlement to a level of health care that is consistent with that which is available to all Canadians, which would reasonably include the expectation of some degree of continuity of care in receiving medical services.

2.50 The CDS' strategic view of continuity of care is explored more fully later in PART 2 of the report under **NEW INITIATIVES**. The narrower concept of a patient receiving coordinated patient care, most preferably through long term doctor/patient relationships is the primary focus of further discussion in the following paragraphs of this section of the report.

Focus Group Feedback on Continuity of Care

2.51 When focus group participants were asked for their views on continuity of care, their responses highlighted both the importance of this concept to the CF and its members and opportunities where it could be strengthened. The impact of continuity of care on CF operations received an almost unanimous response from commanding officers and supervisors. Seventy-six percent of this group either 'agreed' or 'strongly agreed' that continuity of care impacted on the operational capability of the CF. When medical staff and commanding officers/supervisors were polled, a full eighty percent expressed concern that continuity of care in the CF was either 'unacceptably poor', 'falls considerably short of what is available in the civilian sector', or 'falls

[23] Briefing to MND by Capt (N) MF Kavanagh CFMG/ACOS Health Services Delivery, Canadian Forces Medical System, 19 November 1998

somewhat short of that which is available in the civilian sector'. Conversely only twenty percent felt that continuity of care 'is comparable to that which is available in the civilian sector' or 'as good as it can be given the highly mobile nature of medical service providers and patients in the CF'.

2.52 Specific comments raised during the focus group sessions amplified on the statistical results and highlighted reasons why continuity of care is such a critical issue for patients and care providers. The following provides a sample of some of the comments offered by focus group members related to continuity of care:

- the turnover of MOs (medical officers) is so high that patients have to re-explain their medical histories time and time again;
- many patients are asking to see civilian doctors to have more continuity;
- continuity of care provides the most efficient method of ensuring fit soldiers - yet we do not even attempt to do this;
- there is no level of confidence if you see a different doctor each time. There appears to be a sense of apprehension and mistrust of who should be going to the MIR. (This is due in part) because they are not sure which doctor they will see;
- I do not want to see another physician because he would spend too much time reading my file;
- I would choose to have the same military doctor all of the time, one that would know all of the tests that had been done;
- the present doctor has (only) been here two years and it's been the longest;
- something needs to be done with sick parade because the doctor on call is not your doctor. It can take between 2 to 6 weeks to see a specific doctor;
- Doctors are posted out on a regular basis. It would be nice to have a core group of medical staff here; and
- patients need to be able to see the same doctor for the same problem. They also need to see the same doctor all of the time to build a rapport.

2.53 The comments are very insightful as they reveal a number of issues and impacts related to continuity of care. Comments related to difficulties in seeing the same military medical officer highlight that in-garrison care is not yet being delivered as intended in the OP Phoenix model. If the new concept for delivery of in-garrison care was further advanced seeing a military MO would be more the exception than the rule. Base clinics would be staffed primarily with civilian doctors and military MOs would only be available between operational or training/Maintenance of Occupational Competence assignments. As well, it does not appear to be well-understood by patients, COs or some medical staff that the primary deliverers of in-garrison clinical care will increasingly be civilian contract physicians. The fact that there is currently a high attrition rate among MOs should be relatively transparent to the patient in the in-garrison setting as the bulk of the service is intended to be provided by civilians.

2.54 In the **Impact of Op Phoenix on In-garrison Care** section that appears, at para 2.29 of the report, the discussion alludes to weaknesses resulting from the prolonged, fragmented approach to implementing Op Phoenix. While realigning medical resources to respond more effectively to operational demands has been viewed very positively, particularly by those who have had to use those services during deployments, it has been, to some extent, at the expense of in-garrison care. This impact has been exacerbated by organizational and resource application changes being made with military personnel resources, before putting in place a mechanism to ensure that civilian medical personnel would be made available to backfill. This backfilling process was to have been accomplished through the Canadian Forces Health Care Plan (CFHCP) - a key element of the Op Phoenix concept. Indeed what has been found is that in some areas, particularly in remote or rural settings such as CFBs Petawawa and Cold Lake, civilian physicians have not been available to backfill. Hence, efforts by the CF to recruit physicians from the local civilian health care community have proven to be frustrating and time-consuming processes yielding mixed results.

2.55 While the intention of the CFMS was to strengthen continuity of care by having a civilian cadre of doctors to deliver in-garrison medical services, soldiers, sailors and airmen and women are left with the impression that continuity of care has actually diminished. This is, in part, due to an accelerated flow-through of military medical personnel at the base clinics who are regularly being called upon to respond to an increased tempo of operations.

Medical Records as a Mechanism for Strengthening Continuity of Care

2.56 During the CRS interviews several CF physicians commented that the CFMS strives to strengthen continuity of care for the military through the maintenance of comprehensive medical records. The message received by the review team was that the completion of comprehensive medical records was strongly supported by the Surgeon General as patients would be expected to see a range of doctors over their careers. The medical file was seen as the key repository of documented information that would, in many cases, have to substitute for a more direct and personal doctor-to-doctor transfer of military patients.

2.57 In theory this practice makes perfect sense and there are likely many cases where soldiers' files serve as comprehensive records of patients' medical histories. Notwithstanding, the review team was provided considerable anecdotal evidence to indicate that significant numbers of patient records fall considerably short of meeting the CF patient care needs. During interviews with CF medical patients, there were many reported incidents where records had not been completed (e.g., CF 98 Report on Injuries or Immediate Death Therefrom) or medical information was missing from files or block periods of patients' medical histories were missing. This issue will be discussed more fully, later in the Part 2 of the report under **Administrative Procedures**, but the review team was left with the sense that rather than contributing to continuity of care, many of the CF medical records fall considerably short of a reasonable standard and would fuel the discontinuity of care problem that impacts so many CF patients.

CF Policy in Support of Continuity of Care

2.58 The CFMS has policy guidance[24] which demonstrates a CF acknowledgement of the need to provide continuity of patient care whenever possible. At paragraph 6 of CFMO 27-02 under RIGHT TO CHOICE OF PHYSICIAN, the policy states "...Patients should be advised that they have a choice of physician, within the available resources at the unit or the base, and that choice is to be respected whenever feasible..."

2.59 While the policy is well-intentioned, it is of limited practical value in supporting continuity of care. Operational practicalities (obtain care as expeditiously as possible and return to the unit to work as soon as practicable) combined with the heavy patient loads of the physicians available in-garrison make enforcement of the policy for the benefit of the patient difficult. As well, it was highlighted for the team that the front line clerical staff at CF health care facilities - gatekeepers for scheduling medical appointments - have a lot to do with how well the intent of CFMO 27-02 is achieved. When the front line staff are suffering from over work and low morale, which is in turn impacting on their attitude towards the patient, the incentive to implement this policy for the benefit of the patients is low. There is further amplification on this issue area later in Part 2 of the report in the section **entitled MORALE, ATTITUDE AND CAPACITY FOR CHANGE IN THE CFMS.**

Continuity of Care and the Nature of Ailments

2.60 While patients and medical clinician interviewees agreed that continuity of care is an important aspect of patient treatment, there was also general acceptance of the notion that continuity of care is more important for long term chronic ailments and less so for treatment of routine, non-critical, medical conditions. The review team believes that it is necessary to take account of these factors when seeking practical solutions to continuity of care issues.

[24] Canadian Forces Medical Order 27-02, **Patient Rights to Privacy, Protection and Choice of Physician**, 28 January 1993 pp 1.

2.61 In instances where continuity of care was weak, high levels of patient frustration were expressed, particularly in chronic cases where a patient history had been documented and the patient file had become voluminous. A common problem conveyed to the review team was the frustration experienced by both the patient and doctor as the doctor, unfamiliar with the case, would spend most of the appointment time reading the patient file. The patient was left feeling that little progress had been made and the doctor would have invested considerable time in patient history familiarization with little or no time to think about next steps in a treatment plan.

2.62 As well, patients indicated their frustration in trying to orally relay the details of the history of a long term ailment or series of ailments to multiple doctors. Patients indicated that after having explained their conditions several times they would tend to forget certain details and present a fragmented story that left out important information.

Leadership Involvement in Continuity of Care

2.63 The difficulties that the CF and other militaries have experienced in providing continuity of care indicate that appropriate continuity of care requires significant leadership/management involvement. A strong monitoring role must be played, particularly by the CFMS and also by other leaders in the chain of command. If the importance of the concept of continuity of care is not adequately appreciated and communicated to all levels in the CFMS, including staffs from the front-line receptionist right up to the HCC then, it is unlikely to happen.

2.64 In some chronic medical cases that the team observed where there was discontinuity of care, this discontinuity was brought on, in part, by the patient taking matters into his or her own hands. As described in one particular BOI, the patient requested consults with numerous specialists over an extended period of time. Each specialist offered a different assessment of the problem and recommended a different treatment protocol. The patient reached a point where his level of trust and confidence in the CFMS, with a clear oversight role in the whole process, had virtually disappeared. This lack of trust became so significant that the member felt obliged to go outside of the chain of command to resolve his problem.

2.65 As the objective was to provide continuity of care, the CFMS' lack of attentiveness to close management of this patient's case enabled the patient to actually negatively impact his own continuity of care. The dilemma, in this particular case for the CFMS, was trying to be responsive to the patient's requests and demands while at the same time striving to accomplish continuity of care. This is a case where the primary care manager concept, that is in use in the US and discussed later in this Part of the report in the section **Benchmarking Continuity of Care with Other Medical Care Providers,** may have some applicability to the delivery of CF medical services.

Impact of Lack of Continuity of Care

2.66 From all of the evidence gathered relating to continuity of care several major issues surfaced as recurring themes. Firstly, lack of continuity of care is detrimental to morale. Patients who feel they have been repeatedly re-directed from one doctor to the next and are caught up in telling and re-telling their medical histories become so discouraged that, in some cases, their resultant lack of psychological well-being starts to impact on their recovery or induces other ailments that further impedes their ability to function in their jobs.

2.67 Secondly, some patients reported being repeatedly subjected to the same lab tests as their care was transferred from one doctor to the next. This has led to perceptions on the part of the patient that he or she was needlessly being subjected to the same tests time and again because the system had forced a physician change upon them rather than for any sound medical reason. The patients reported to the team that they felt they would not be put through all of these inconveniences (repeated tests, re-explaining their medical histories to different physicians etc.), if the CF were able to provide a better level of continuity of care.

2.68 The third significant impact of a lack of continuity of care is the impact of a prolonged and disjointed treatment program that may result as different doctors become involved in the case imposing their different views of how a treatment program should be pursued. Whether one approach is better than another is a matter of professional judgement, but the patient often perceives such circumstances as negatively impacting on their care.

Benchmarking Continuity of Care with Other Medical Care Providers

2.69 In comparing the CF's continuity of care situation with other military and civilian organizations, the review team benchmarked continuity of care in National Defence with the Canadian civilian sector and other defence organizations.

2.70 Canadian Civilian Sector. Continuity of care in the Canadian civilian sector has evolved considerably in recent years. A generally more mobile population is not experiencing the same 'cradle to grave' doctor/patient relationship that was more prevalent in the past. Where a typical family in the past may have had a 20 to 30 year relationship with a single family physician, this is less common today with families and physicians both moving more frequently.

2.71 As well, the advent of the walk-in clinic which is a common phenomenon in large and medium sized communities has changed the doctor/patient relationship. Prior to the walk-in clinic Canadians would take time off work during the day to attend an appointment with the family physician or take a family member to do so. The convenience of ready accessibility to neighbourhood walk-in clinics with evening and weekend hours is changing the continuity of care dynamic. While family physicians sometimes have arrangements with after hours clinics for obtaining patient information, very often such arrangements do not exist. It is clear that continuity of care for some civilians is not as consistent as it once was. Where the dynamic differs somewhat between military members and civilians is that civilians generally decide the

extent to which they have continuity of care whereas military members do not normally have that option. It is noteworthy that in spite of continuity of care being one of the important elements/ principles of the practice of family medicine, the realities of societal changes offer considerable potential to impact this aspect of medical care.

2.72 Other Defence Organizations. The review team noted that medical groups in other defence organizations are facing or have faced similar problems related to continuity of care as the CF. In consultation with the New Zealand Defence Force (NZDF), the review team learned that it too has downsized the health services aspect of its defence capability and is becoming increasingly dependent upon the civilian sector to meet its health care needs. The NZDF attributes improved continuity of care for its soldiers to increased civilianization of medical treatment personnel, and vigilance on the part of the NZDF Health Services organization to ensure comprehensive clinical notes (patient records) are completed, maintained, accounted for and kept readily available in support of patient care. For military medical personnel, the NZDF is also now striving for longer postings at particular locations as another strategy to further strengthen continuity of care.

2.73 The Defence Medical Service of the United Kingdom's (UK) Ministry of Defence (MOD) is making efforts to strengthen continuity of care through the implementation of a 'cross-service' medical information system including a central data base of medical information and medical categories. The UK has recognized, as has Canada's CFMG, that when you have an organizational/operational structure that does not always support continuity of care, there are strategies that can be pursued, such as sound information management, to compensate for other organizationally inherent impediments.

2.74 The US Department of Defence (DoD) has its TRICARE Medical Plan which has its own built-in strategies for strengthening continuity of care. One such strategy is the assignment of a Primary Care Manager (PCM) who serves as the members' single point of contact for non-emergency healthcare. The US service member may select a PMC at a military hospital or clinic or a civilian professional who is a member of the contracted TRICARE network in the community. The PCM provides and coordinates care, ensures the maintenance of health records and recommends patient access to preventative and wellness services. The PCM also arranges for specialist consults or hospital admissions when necessary. The concept of the PCM role is particularly appealing from the perspective of accountability for patient care. The appropriate use of a position such as this offers the opportunity, through the principles of responsibility and accountability, to ensure continuity of care is achieved to the extent practicable and risks of patients becoming mired in health care bureaucracy, rather than being treated, are significantly reduced.

2.75 RCMP Experience with Continuity of Care. The RCMP is also concerned about continuity of care for its members, but it is less of a problem for them than for the CF. RCMP personnel can choose their health care provider in the local community, hence their continuity of care would be more on par with a Canadian civilian. As well, RCMP members tend to be generally less mobile than CF members which again contributes to the building of a longer term doctor/patient relationship.

2.76 What is particularly noteworthy among the experiences of all of the benchmarked organizations is that increased civilianization is generally accepted as a common ingredient to improving continuity of care. This is also consistent with the CF's strategy for delivery of in-garrison patient care.

Conclusions Related to Continuity of Care

2.77 The review team has concluded that:

a. continuity of care is a fundamental concept in the practice of family medicine and is not perceived as being delivered to the extent that it could or should be in the CF;

b. allied military and paramilitary organizations are implementing similar strategies to those being pursued by the CFMS by striving to improve continuity of care for their personnel through greater use of civilian medical resources. There are other strategies that some of the allies are implementing in addition to civilianization that may warrant consideration by Canada. It would be worthwhile for the CFMS to be aware both of initiatives that worked for other defence forces and those that didn't, in order to derive maximum benefit from these other experiences;

c. achieving continuity of care is generally considered by the medical profession to be more important in the treatment of chronic cases than in the treatment of ailments of a more routine nature; and

d. the extent to which continuity of care is not achieved in the military impacts patient morale and, at times, threatens the quality of care being received.

Recommendations Related to Continuity of Care

2.78 It is recommended that:

a. initiatives to facilitate the hiring of civilian physicians for temporary and indeterminate assignments, such as the Designated Provider Plan and other strategies, be pursued as a matter of priority;

b. strategies that other nations have pursued (e.g., primary care manager in the US military) be examined for their applicability either site-by-site or on a more national basis in the CFMS;

c. Surgeon General highlight for all CFMS staff through the Branch Newsletter, personal site visits, the Defence Information Network web site, and other venues, the importance of achieving continuity of patient care to the extent practical and implementable in the in-garrison setting, with the highest priority being placed on members with chronic ailments;

d. procedures be developed at health care centres which will optimize the opportunity to provide continuity of care to the patient and implement CFMO 27-02 to the maximum extent possible;

e. steps be taken to ensure that continuity of care is featured as a curriculum item in all CF courses that have application to clinical and administrative matters relating to the delivery of in-garrison care; and

f. CFMS personnel and leaders in the operational chain of command be reminded of their leadership responsibilities to support CF members in receiving continuity of medical care.

ADMINISTRATION OF TEMPORARY MEDICAL CATEGORIES

2.79 A specific tasking objective of the CRS review was to examine the administration of temporary medical categories' (TMC)s to determine the validity of the process, if it is serving its intended purpose - from both the members' and CF's perspectives, and if changes should be made to improve its effectiveness. As the assignment of 'Temporary Medical Categories' is premised on the 'Medical Category System' (MCS) the following two paragraphs are intended to introduce the reader to the more generic MCS concept before examining the specifics of TMCs.

Background on Medical Categories

2.80 A description of CF Medical Categories and how they are to be used is provided in CF medical policy[25]. The following excerpt to the policy alludes to the purpose of the medical standards supporting the category system: "...The medical standards are expressed in a numerical category system to communicate to administrative and employment authorities a concise medical opinion of the employment capabilities of recruits and serving members..." Medical categories are determined by assigning gradings to the following six criteria: Visual Acuity, Colour Vision, Hearing (Auditory Acuity), Geographical Factor, Occupational Factor and Air Factor.

[25] CFAO 34-30, Medical Standards for the Canadian Forces

2.81 The policy also includes an annex which specifies minimum medical standards that must be met in order for the members to serve in their respective trades. Minimum standards of medical fitness are established for each occupation. If the member's grading falls below the minimum threshold then resultant career implications become an administrative matter that must be dealt with by a Career Review Board (Medical) (CRB(M)). When any one of the Visual Acuity, Geographical Factor, or Occupational Factor are graded at level 6 (1 reflects the highest level of medical fitness and 6 reflects the least medically fit), the member is deemed to be unfit to perform duties as a CF member. At this stage, the medical authority would normally recommend the member's release.[26]

Background on Temporary Medical Categories

2.82 The CF has found that throughout a member's career there are times, whether as a result of injury or illness, when it becomes necessary to temporarily lower one or more factors of the medical category until such time as the member recovers to an acceptable level of medical fitness. While not explicitly discussed in any of the policies examined, the review team was advised that there are two main purposes for temporary medical categories:

a. to remove the member from the operational environment for his or her own safety, as well as that of the unit; and

b. to give the member an opportunity to receive appropriate medical treatment, heal and prepare to return to the unit.

2.83 The CF policy which provides for administration of temporary medical categories (TMCs)[27] specifies that the temporary category may be assigned for periods not exceeding six months and maybe renewed once before referral to NDHQ for review. It also specifies that a decision should be made on a permanent category as soon as the patient's condition becomes stable or it is not expected that the member's condition will improve in the foreseeable future. The policy also states that it is only in rare cases that TMCs should be extended beyond 12 months and if such an extension is deemed appropriate, NDHQ approval is required.

2.84 The review team found that the concept of temporary medical categories is well-founded in principle, but does not consistently function smoothly in practice. The next several paragraphs will discuss some of the dynamics and resultant impacts of the application of temporary medical categories from the perspectives of patients/members, commanding officers, and medical personnel.

[26] Q,R & O 15.01- 3b - On medical grounds, being disabled and unfit to perform his duties in his present trade or employment, and not otherwise advantageously employable under existing service policy.
[27] A-MD-154-000/FP-000, Chapter 3 - The Medical Category System - para 9, p.3-8, September 1995

Application of Temporary Medical Categories - Patients/Members Perspectives

2.85 Throughout the study the review team found during focus groups, interviews and as a result of extractions of information from Boards of Inquiry, Summary Investigations and other studies that the experiences of patients/members with TMCs was very diverse. Some had very positive experiences indicating that the process worked as intended and served them well. Others had very opposite experiences that were very frustrating and resulted in high levels of stress for the member. Review team conclusions in this area were formulated based on polling and discussions during focus group sessions and extensive interviews focused specifically on the topic of TMCs.

2.86 Of the patients who had experience with TMCs, 74 per cent reported that medical categories were 'not explained at all', 'poorly explained' or only 'explained to some extent'. The remaining 26 per cent felt that medical categories were fully explained. A common complaint of CF members assigned TMCs was that the related processes and policies were not well-explained to them and, in many cases, were not well-understood by civilian physicians assigning them. During the course of the review a brochure explaining TMCs was developed and issued by Surgeon General to base clinics across the country. The review team views this as a positive initiative on the part of the CFMS and sees potential for this document, when used in conjunction with the physician/patient consultation, to strengthen patient understanding of the TMC process and possible career implications.

2.87 As in any administrative process there are various preferences on the outcome of a TMC process from a range of involved stakeholders. The following is a discussion of some of the dynamics from the patient perspective. For interviewees who felt that the process worked well, they were generally satisfied that the TMC protected them from further injury, protected their colleagues from risk of injury, and that they had a chance to heal before returning to full duty.

2.88 Some members expressed concern about being placed on temporary category for fear of being stigmatized as being 'a laggard' or 'lazy'. Others were concerned about the career implications - 'What if I don't get better?' or 'What if I take too long to recover?' 'Will I be released?'. In spite of the many assurances given to members from the highest levels of the military, many interviewees continue to be very uneasy about the medical system. There appears to be a significant degree of mistrust, among members, about whether the CFMS or other administrative processes that follow-on from medical recommendations are functioning in the best interests of the member.

2.89 There were also differing views on the timeliness with which their TMCs were resolved. Some patients indicated that they were perfectly satisfied with the time that elapsed during their TMC period. As the local HCC has the authority to grant 1 TMC per patient for a period of up to six months and renew that TMC once, there is a 12 month time horizon during which the base level medical services can resolve the medical problem before referral to NDHQ becomes necessary.

2.90 In situations where TMCs had to be referred to NDHQ, the individual patients had differing views on how quickly they wanted their cases resolved. For members who wanted early decisions that would result in them being put on a permanent category, paving the way for release, they were frustrated with the length of time the process took. For others who were nearing a critical retirement date, destined for the unemployment lines or in the latter days of terminal illness they were less anxious to have their TMCs dealt with out of concern that it might expedite employment termination with resultant loss in benefits.

2.91 NDHQ's ability to process extended TMCs in a timely way during the past year has been impaired by staff shortages at D Med Pol, due in part to the CF's increased tempo of operations. The impact of a backlog of TMC files requiring NDHQ decisions is discussed more fully in a later section of Part 2 of the report under the heading '**Impact of Unresolved Temporary Medical Categories at NDHQ Ottawa**'.

Application of Temporary Medical Categories - Commanding Officers' Perspectives

2.92 Commanding Officers and supervisors also expressed a spectrum of feelings about the TMC process. While commanding officers generally recognized the value and importance of such a process, they also acknowledged the frustrations that result when the process does not function as intended. While there are arrangements that can be made if the member is on a very short term TMC or assigned a permanent category, the worst situation for the CO is if the member is on an extended TMC. A short term TMC is normally manageable as the unit can make some stop gap provisions through doubling up on tasks, borrowing from another unit etc. A longer term TMC, which lasts in excess of six months can result in a member being placed on a Medical Patient Holding List (MPHL). This is not a straight-forward process, however as the CO must be able to justify that replacement of the unfit member is essential, and then make application with the appropriate career manager to place the member on MPHL. The major challenge for the career manager in today's environment is finding a suitable replacement, at the right rank and in the right trade when drawing on a significantly diminished human resource pool.

2.93 The most difficult cases to deal with from the CO/supervisor perspective are those TMCs that are renewed numerous times, yet the CO is not provided a replacement member. These longer term TMC cases pose the greatest management challenge for COs for the following reasons:

a. the member on TMC must be administered differently than healthy members, complicating the COs leadership responsibilities;

b. the unit is weakened by the missing individual and the ill or injured member's tasks must be completed by the remaining healthy personnel;

c. the CO must be constantly assessing and re-assessing options to compensate for lost productivity and incomplete taskings resulting from the void left by the missing member; and

d. all of these factors are compounded when more than one member of a unit is on TMC.

2.94 The pressures of running short of personnel due to TMCs are greater now for COs than they have been in the past, in a downsized CF, which has resulted in a 'one-person for one-job' military with little flexibility and redundancy. If the CO applies his or her influence to have the member taken off of TMC and returned to service, and the doctor acquiesces to those pressures, then the patient and the unit are put at risk. If the patient becomes more seriously injured, when taken off of TMC too early and permanent injury results, then the military has done a disservice to the member and the military loses the extensive training and experience investment in that soldier. With 71 per cent of commanding officer focus group participants either 'agreeing' or 'strongly agreeing' that it is necessary to influence CF medical practitioners in matters related to patient care in order to meet the operational needs of the CF the occurrence of such a scenario is not inconceivable.

2.95 The COs' frustrations with the TMC process became apparent in their focus group response to the statement 'the administrative process of temporary medical categories works very well'. To that statement a full 78 per cent of supervisors and commanding officers either 'disagreed' or 'strongly disagreed'. Only 22 per cent 'agreed', with none 'strongly agreeing'.

2.96 Another issue from the CO perspective is applying pressure for the TMC system to be used to initiate release of a soldier who is not performing well. The review team was advised that this approach is sometimes pursued by COs in the hope that removal of a poorly performing soldier through a medically initiated mechanism may be more effective/timely than through a more appropriate administrative process.

Application of Temporary Medical Categories - Medical Professionals' Perspectives

2.97 Medical professionals generally saw their roles as being patient advocates who wanted to make sure that any medical or medically related administrative decisions taken were made consistently and with the best interests of the patients in mind. Of the medical staff polled in the focus groups, 61 per cent 'strongly disagreed' or 'disagreed' that the administrative process of TMCs works very well. Forty per cent agreed that the process works well and no medical staff 'strongly agreed'

2.98 CF medical officers and civilian doctors providing service to CF members indicated the existence of varying levels of pressure on their medical decision-making from several sources. For the patient who does not want to be placed on a TMC, the MO or civilian contract doctor can get pressure from the member *not* to be put on TMC. The danger here is that a CO can be put at risk by feeling he or she has a fully fit unit capable of meeting the demands of the job, when in

reality there may be weaknesses that are unknown to the leadership. Medical staff reported other instances where the patient pressured the doctor to assign a medical category in what appeared to be an effort to avoid certain operational taskings or deployments.

2.99 A third pressure felt by the medical staff, related to the assignment of TMCs, comes from the commanding officer. Most MOs and civilian contract doctors reported incidents to the review team they had felt pressured by the CO to either apply or not apply a TMC. At the unit level when a junior GDMO is approached by a senior commanding officer in an attempt to influence a medical decision, the MO is being put in a position that poses significant professional/ethical dilemmas that are not easily dealt with.

2.100 Medical staff also reported instances where pressure was applied by COs to disclose the nature of the members' ailment so that the CO could have a more complete understanding of circumstances surrounding the members' medical conditions in order to fulfill their command responsibilities. This was another frustration for medical officers who are obliged by their rules of conduct and professional ethics to maintain patient confidentiality. The medical category system is specifically designed to enable the doctor to assign restrictions based on the six generic factors, providing the operationally relevant information to COs without breaching patient confidentiality.

Application of Temporary Medical Categories - Leadership

2.101 A recurring theme that emerged during our review of TMCs was that the process is not a mechanical one. The human dimensions and dynamics related to TMCs makes it necessary for either periodic or ongoing leadership intervention and involvement. When the system breaks down it is frequently due to insufficient involvement on the part of leadership in the chain of command. The following discussion highlights why strong leadership plays a key role in an effective TMC process.

2.102 The major gaps in administrative processes related to TMCs appears to be for those longer recoveries, anywhere between a few months to several years, where one or more six month TMCs are required to provide for an appropriate healing or recuperation period. The TMC is an administrative process not a medical one, yet many CF members see it the other way. When asked if the CFMS receives the criticism when the TMC process does not fully meet the expectations of patients 94 per cent of CFMS respondents 'agreed' or 'strongly agreed' with the statement. Only 6 per cent either 'disagreed' or 'strongly disagreed' with the statement. During focus group discussions CFMS personnel indicated their frustrations with being the primary recipients of complaints with deficiencies in the TMC process. In their view it is a military chain of command and leadership responsibility to ensure that appropriate administrative systems are in place to ensure that while on a TMC, the members' circumstances are appropriately taken account of and his or her administrative requirements are attended to.

2.103 Further frustration relating to TMCs was reflected in medical personnel focus group responses to the support received from the chain of command when medical personnel recommended the assignment of TMCs. When medical personnel responded to the statement 'the recommendations for assigning TMCs are respected by the chain of command' 57 per cent of respondents either 'strongly disagreed' or 'disagreed'. Forty-two percent 'agreed' and only 1 per cent 'strongly agreed'. An analysis of subsequent discussion led the review team to conclude that CFMS personnel were looking for stronger support from military leadership in order that the TMC process could work effectively.

2.104 The need for leadership intervention and involvement became apparent during discussions related to two statements that were responded to by the commanding officer and supervisor focus groups. To the statement 'members on TMC are sometimes viewed as abusing the system and may become ostracized by their units' a full 82 per cent of supervisors and COs either 'strongly agreed' or 'agreed'. The remaining 18 per cent either 'disagreed' or 'strongly disagreed'. In follow-on focus group discussion it became apparent that leaders generally recognized the need to intervene and work with the medical personnel to minimize abuse of the TMC system. As well, there was recognition that leadership played a role in moderating the extent to which members on TMCs felt ostracized by their units.

2.105 Leaders clearly recognized that they had responsibilities in the TMC process when 89 per cent of CO /supervisor respondents 'agreed' or 'strongly agreed' with the statement 'the chain of command should play a larger role in monitoring and managing people who are assigned TMCs.' Only 11 per cent 'disagreed' with the statement with no one 'strongly disagreeing'. With such a high percentage recognizing their leadership responsibilities, the key for the CF is to secure commitment from a larger portion of the CO/supervisor group to 'walk the talk' when it comes to demonstrating leadership in the administration of TMCs.

Information Management in Support of Temporary Medical Categories

2.106 As will be discussed in the later section '**Information Management/Information Technologies**', a comprehensive IM/IT solution to support patient care in the CFMS is not scheduled for full implementation until 2008. As it functions today, the CFMS is operating in a largely paper-based environment. Systems that have been developed to facilitate the delivery of patient care are generally local level initiatives using commercial off the shelf software. At several bases, locally developed IM/IT solutions have been put in place to specifically assist in the management of TMCs and to monitor individuals with this status. As discussed later in the **Migration of Ideas** section of the report, sharing of ideas on locally developed IM/IT solutions offers the opportunity to leverage on work already done and readily put a capability in organizations that need it.

2.107 For individual units, the review team was advised that the unit medical officer (UMO) will use an IT system both to obtain TMC and medical information related to the soldiers and have a means of providing the administratively related information to COs. One unit MO pointed out how she used IM/IT to ensure that appropriate medical follow-up was taking place

and every effort was being made on the medical side to ensure the members were brought back to a level of medical fitness as soon as possible. The point that was made to the team was that wings/bases/formations could not wait for the corporate level health services project G2800 to put systems in place to support such efforts as the administration of TMCs and these interim solutions could be established at reasonable cost and in a reasonable timeframe.

Impact of Backlog of Unresolved Temporary Medical Categories at NDHQ

2.108 As indicated in earlier sections of this part of the report, for much of this past year, files of patients with TMCs extending beyond 12 months have been flowing into NDHQ for rulings at a greater rate than DGHS staff has been able to provide rulings and administratively process. By the late Spring of 1999 there were some 1200 unprocessed files that had built up in the Directorate of Medical Policy (D Med Pol). A combination of an unusually high volume of incoming files coupled with personnel shortages being experienced in D Med Pol brought about the backlog situation. As D Med Pol staff pointed out to the review team, a key to making consistent and fair assessments of TMCs is to maintain a high level of continuity among the reviewers. The concern for loss of this continuity caused D Med Pol to be hesitant to bring in short term replacements to try to address the backlog problem.

2.109 The lack of progress being made on the backlog was a source of concern for the review team, which had heard of numerous incidents of members in the field whose careers were in limbo or lives were on hold, or both, pending resolution of their TMC. As well, COs were becoming frustrated that unit effectiveness was being diminished and their administrative burden increasing for every member awaiting a decision on their TMC. Despite best efforts on the part of the CFMS - including bringing in some temporary help and reassigning HQ staff and other measures – by early June 99 there was still a backlog of some 1000 files.

2.110 Towards the middle of June, D Med Pol launched a blitz to address the backlog. By August the number of unprocessed files had been reduced to 300 and it was estimated that they would be completely up to date by October 99. As the responsible director pointed out, progress in reducing numbers of unprocessed files was only accomplished through extraordinary measures having been taken which included no issuance new policy throughout the blitz period.

Opportunity Cost to Delayed Processing of TMC Files

2.111 It is noteworthy that there are opportunity costs to delays in processing TMC files. While members are on TMC, and not fully performing at their jobs, they are often underemployed or misemployed. Also, members are in a state of limbo with respect their careers and lives as they wait for the decision to come down from Ottawa either indicating that their temporary category will be extended or their file will be directed through the Career Review Board (Medical) process for more definitive career action.

2.112 There is generally a significant benefit to the taking of timely decisions related to processing TMC files. The impact of not taking decisions on these files is to negatively affect operational capability, individuals' personal lives and has a dollar impact to the CF and the Department as well.

Conclusions Related to the Administration of Temporary Medical Categories

2.113 The review team has concluded that:

a. the temporary medical category concept is premised on sound rationale;

b. while the TMC process is sound, there are administrative aspects that could be improved upon for the benefit of the member and the CF;

c. patients who are currently on or who have been on TMCs, for the most part do not have a good understanding of the process;

d. members are distrustful of the TMC process from a career implications perspective;

e. members often feel ostracized by their peers and sometimes their superiors when they are assigned a TMC;

f. while members had varying views and opinions on how quickly they wanted decisions taken related to their TMCs, it is generally to the benefit of the member and the CF for these matters to be resolved in a timely way;

g. a combination of significant numbers of members assigned repeated TMCs and a sparing use of the medical patient holding list serves as a major frustration for COs who are trying to do the right thing for the patient, but must also accomplish the operational mission with reduced resources;

h. MOs may be subjected to pressures from members and more senior COs on decisions related to TMCs - these pressures pose significant ethical dilemmas for the MOs;

i. while lack of leadership involvement can be linked to a number of cases where the TMC process has not functioned as expected, COs and supervisors recognize that the process is an administrative one and they have a significant role to play to make sure it functions well;

j. IM/IT offers the potential to assist in the administration of TMCs and some standalone systems in the field are being developed, used and contributing to the administration of TMCs;

k. there are significant costs attached to having members on TMCs; and

l. to their credit, D Med Pol staff have made considerable progress in recent months to reduce the backlog of TMC files referred to NDHQ to manageable levels.

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Recommendations Related to Temporary Medical Categories

2.115 The review team recommends that:

a. efforts be made to improve patient knowledge and awareness levels on temporary medical categories;

(1) all CFMS clinical staff should be knowledgeable on the TMC concept and process and be ready to answer frequently asked questions on TMCs, and

(2) supplies of the brochure recently issued by D Med Pol on TMCs should be made readily available in medical facilities where in-garrison care is provided to CF members and copies should be distributed freely to members;

b. leaders be sufficiently involved in the administration of TMCs so that the member is not administratively put off to the side, without sufficient supervision or support;

c. leaders fulfill their responsibilities to ensure that colleagues of the member on TMC are aware of the process and understand why TMCs are used;

d. as a general rule, decisions related to the administration of TMCs be taken in as timely a way as possible and practical, taking account of the best interests of the patient, the unit and the CF;

e. training venues that introduce MOs to the practice of medicine in the CF and address the concept of TMCs, make provision for educating the MO not only on mechanics of TMCs, but also on some of the related human resource dynamics; and

f. when Surgeon General and other CFMS personnel are briefing various forums of CF leadership that they take the opportunity to highlight leadership responsibilities related to TMCs and continuity of care.

CFMS ORGANIZATIONAL AND COMMAND AND CONTROL ISSUES

Background - Command and Control of In-Garrison Care

2.116 The Canadian Forces Medical Service (CFMS) and the organizational structures and procedures developed to exercise command, control and professional direction over its many components, had evolved pre-Op Phoenix primarily to meet the peacetime requirements of the CF. The assumption that peacetime organizations and procedures could readily be adapted to the requirements of a sustained operational deployment was criticized and challenged in several management reviews of the CFMS in the early 1990's and as a result, the Op Phoenix review was undertaken to develop a new, operationally-oriented, viable and cost-effective health support system. The Op Phoenix final report recommended a re-engineering of the system to provide both operational and in-garrison medical support. Implementing and managing the proposed system would require a significant restructuring of the CFMS command and control system.

2.117 Prior to OP Phoenix, medical resources throughout the CF were, for the most part, structured and organized for the provision of in-garrison care. First and second line medical resources assigned to the environmental commands were organized in units to support operations; however, they were frequently double-hatted and personnel were utilized to provide in-garrison health care to the CF population at the respective CF base or units where they were garrisoned. Third line resources were organized and structured to provide in-garrison health care. Personnel, when available, were drawn from these garrison-type facilities to form operational medical components to support specific operations. This proved to be problematic, as personnel could not always be made available to deploy because of their involvement and commitment to the provision of in-garrison care. Thus the CFMS was not always able to provide the medical component to the extent required to support operations.

2.118 The Op Phoenix review resulted in a fundamental change in the role and priorities of uniformed medical personnel. The Op Phoenix objective was to structure CFMS personnel in units to support CF operations and to utilize these resources to provide in-garrison health care only when available. The intent of involving CFMS staff in in-garrison care was to provide a venue for various uniformed medical occupations to maintain their clinical and professional skills in a state of readiness for deployment. A small uniformed management component was established at each major CF base to coordinate in-garrison health care delivery which was to be provided primarily by civilian resources and supplemented by CF operational health care personnel assigned to the respective bases when available.

2.119 Canadian Forces Hospitals (including National Defence Medical Centre (NDMC)) were disbanded as units of the CF as a result of Op Phoenix. The responsibility for the provision of in-garrison health care was assigned to the Formation or Base Commander who was given the responsibility to determine the extent to which base medical facilities would continue to provide in-garrison health care.

2.120 As part of the OP Phoenix restructuring, a Health Care Coordinator position (previously the Base Surgeon) was established at each major base. The HCC would be responsible for in-garrison health care delivery. The HCC coordinates the delivery of health care services as outlined in the CF Spectrum of health care utilizing available operational military health care personnel and civilian health care resources. The HCC is supported by a military administrative component (usually a health care administrator). Services required beyond the capability of the base facility are normally contracted from the local civilian community. When the assigned CFMG military personnel are withdrawn for operational deployment, exercises, training activities or leave, the HCC must obtain either contract civilian health care professionals to provide services at CF facilities, or refer the patients to the local community for the health services that they require.

Implications of Command and Control on Delivery of in-Garrison Care

2.121 A major factor currently affecting the delivery of in-garrison health care is the lack of a clear understanding with regard to responsibilities, authorities and accountabilities for meeting patient needs. While the current health care structure resulting from Op Phoenix can support an operationally oriented CFMS, the day-to-day activities at all levels still appears to be focussed, for the most part, on the provision of in-garrison health care services. This gives rise to potential problems when various levels of the health services command and control structure, which is organized to support an operationally oriented service, become involved in the decision-making processes that impact in-garrison care.

2.122 While the responsibility for in-garrison medical care is clearly assigned, accountability for its delivery is not. Op Phoenix indicated that the responsibility for in-garrison health care delivery rests with the Formation and Base Commanders, with the HCC position at each base established to coordinate the delivery of in-garrison health care on behalf of the Base Commander. However, Base Commanders are not necessarily given appropriate control for the operation of their medical facility. While the HCCs are responsible to the Base Commander for the delivery of in-garrison medical care, both the environmental command medical staff and the NDHQ (CFMG) medical staff are significantly involved in many of the decisions that should be made at the base level.

2.123 There is a dual chain of command for medical resources providing in-garrison support. While the Base Commander is responsible for in-garrison health services, CFMG detachments provide the uniformed health care personnel to support in-garrison health care when they are available. However, frequently the staff provided is not sufficient to meet the patient volumes. In addition, during deployments or training of military medical personnel, the in-garrison health care delivery establishment must be augmented. Current NDHQ policy established by DGHS/CFMG is that the HCC can replace physicians and other health care providers when CFMG detachment personnel are absent for operational deployments or training, but they are not authorized to hire replacement staff when CFMG personnel are absent for annual leave, sick leave, career courses or other absences. Some of these absences may be from three weeks to four months. As a result, while patient volumes at a base medical facility may require a minimum

physician/patient ratio on an ongoing basis, the HCC cannot ensure that sufficient resources will be available to meet the requirement. Similarly, decisions on the availability of CFMG staff are made independently of the workload, requirements and priorities of the in-garrison health care centre. The fundamental question arises as to whether it is DGHS/CO CFMG, the Base Commander or the HCC who can be held responsible for the delivery of in-garrison care.

2.124 The HCC position was identified and established for the sole purpose of coordinating the delivery of in-garrison medical care. Pre-Op Phoenix, the Base Surgeon supported both the in-garrison health care requirements and operational medical support requirements for the Base. Currently most HCCs appear to be still functioning in the old Base Surgeon role. This fact alone has the potential of compromising in-garrison medical care as the attention of the HCC and those uniformed medical resources available to them at any one time may be diverted from providing in-garrison care to other military taskings.

2.125 Although the HCC position is established at each base, it must report to NDHQ DGHS/CFMG, either directly or through the medical staff of their formation headquarters, on matters related to supplementary health care funding and staffing requirements. Base Commanders, who may not be cognizant of local health care delivery issues, are in a position to place demands on the CF medical system without being responsible for their costs. By way of example, a Base Commander may insist that a Base Medical Clinic provide sick parades on weekends and holidays, thereby incurring physician costs for weekend and on-call coverage. These costs are funded from the DGHS O&M budget rather than base funding. While a Base Commander should be able to direct how in-garrison health care will be provided to CF members on their base, there should be an accountability for the associated costs to insure that incentives exist for bases to manage their health care in the most efficient way.

2.126 In-garrison health care services are being provided in an environment of conflicting command and control relationships. The provision of uniformed medical staff is shared between CFMG detachments, first and second line medical staff of the Environmental Command (field ambulances, brigades etc.), and Base staff through the Health Care Coordinator and administrative officer. While the Op Phoenix concept implies that in-garrison care is to be provided by civilian providers, it is highly dependent on the availability of uniformed medical officers and other health professionals of the CFMG Operational Training Units (OTUs) and first and second line Command staff in order that in-garrison care can be sustained. This results in the requirement for CFMG staff to be interlaced with Command and base staff working within a health care centre managed by an HCC who reports to the Base Commander. As a result, the delivery of in-garrison care is very much dependent on the successful co-ordination of resources of three separate chains of command, highly influenced by personalities rather than principles of organization. Delivery of in-garrison care suffers from a lack of 'unity of command' where the medical resources providing service are responsible to the CO CFMG, the Environmental Commands and the Base Commander.

2.127 While the current implementation of the Op Phoenix model has not resolved this command and control issue, an appreciation of the problem by all levels of management may assist managing in the current environment. While the Base Commander and the HCC are responsible for providing in-garrison care, its delivery is dependent on support from Command medical resources, the CFMG detachment personnel and field hospital resources. By integrating and coordinating resources from three separate organizations, each with competing mandates, leadership styles, taskings and priorities, it is understandable that delivery of care to the patient may be impacted by these complexities. Medical officers employed in the CF medical facilities indicated to the review team that productivity and efficiency in delivering patient care is being negatively impacted by the need to manage and balance the command and control interrelationships that occur behind the scenes.

2.128 The positions of CO CFMG and DGHS are filled by one individual but fulfill separate responsibilities. The Director General Health Services (DGHS) holds the appointment of Surgeon General for the CF and is responsible for overseeing the provision of general medical and dental services to the CF, overseeing the continuum of operational health care support, ensuring the professional development of health care personnel and ensuring that the requirement for health care resources are properly identified. As the CO of CFMG, the incumbent is responsible for force generating the operational (third line) Canadian Medical Group (CMG) and the delivery of strategic health support (fourth line). While the DGHS position has no command authority over CFMS resources, the CO CFMG has command responsibility for approximately one third of the CFMS medical resources. The remaining two thirds of the medical resources are under the command and control of the ECSs. While one individual has responsibilities for both strategic management of the medical service (DGHS) and for operational medical activities (CO CFMG), there is no corporate direction given to the remaining medical resources which belong to the ECSs other than through professional influence. As a result, the in-garrison health care interests of the CF patient must be addressed through three chains of command which are not always consistent in their approach or priorities.

2.129 The lack of unity of command over medical resources providing in-garrison care causes practical problems in supervising, ensuring familiarity with and enforcing administrative and operating procedures, and ensuring provision of a consistent level of service. The HCC has managerial responsibility for the operation of the health care facility but does not have any line authority over the medical personnel who are providing services other than the health care administrator and the civilian physicians employed on contract. As a result, the HCC cannot provide direct supervision to the clerical and support staff who are made available from CFMG detachments or command units. Similarly, such staff do not have a commitment to working at the health care centre, they are not necessarily consistently available for employment at the CF medical facility, and therefore they are often unfamiliar with the administrative and operating procedures of the CF medical facility which would facilitate providing a consistent level of service.

2.130 Med As are not assigned on a permanent basis to in-garrison health care centres. All Med As are assigned to operational units and are only made available to base clinics if their unit is in garrison and arrangements have been made to supplement base services or to provide OJT . Availability of MOs from CFMG or Command staffs is on an 'as available' basis as well, preventing the HCC from committing to long term planning or scheduling activities. As a result, some HCCs do not schedule appointments more than four weeks in advance due to the vagaries of the staffing of medical personnel, as they cannot be assured that sufficient medical staff will be available to provide for patient needs, thereby affecting the level of in-garrison medical services.

2.131 A recurring discussion regarding the command and control of the CFMS is the potential for centralizing all medical resources into one command structure. While organizational theory and precedents set by other functional specialists may support this concept, implementation of such a fundamental restructuring in the near term does not appear feasible. As discussed at para 2.193 the CFMS is described as a 'change fatigued' organization characterized by a general spirit of low morale. As the dramatic changes brought about by Op Phoenix are still being felt by the CFMS Branch, it is doubtful further large scale organizational or structural changes would have sufficient broad support and commitment from either the CFMS branch or the Environmental Commanders. The existing mandate to provide an operationally oriented medical service, which was established by Op Phoenix, is presently being met by the current structure. While problems are inherent in the current command and control structure which inhibit optimal provision of in-garrison care, implementation of the administrative, procedural and staffing recommendations made throughout this report should ameliorate the situation in the immediate term to ensure that the mandate established for the CFMS can be satisfactorily achieved, while also improving day-to-day in-garrison care. It is incumbent on the CFMS to demonstrate to members of the CFMS that optimal in-garrison care is and can be provided regardless of the command and control structure under which it is operating. Further fundamental changes to the organization in the short term, while aspects of Op Phoenix are still being implemented, would in all likelihood, divert attention from implementing initiatives that are now underway to improve patient care.

2.132 In the longer term (18 to 24 months), serious consideration could be given to establishing a centralized health services organization, placed either under one ECS or as a national support entity. Such an organizational concept would have the potential to provide for a more efficient health service, based on current medical needs rather than past precedents. Conceptually, such an organization would generate the required health care personnel to support the various units and elements of the CF, while promoting system-wide consistency, quality of service and clinical management practices, as well as facilitate the development and implementation of an enterprise-wide health information system. There would also be greater flexibility in moving personnel between the various formations to support both operational and in-garrison health support requirements.

Conclusions Related to Command and Control of Delivery of in-Garrison Care

2.133 The review team has concluded that:

a. a lack of clarity of responsibilities, authorities and accountabilities is having an impact on the delivery of the care;

b. delivery of in-garrison health care is very dependent on the successful coordination and integration of the resources of three separate chains of command. This structure is highly influenced by personalities and differing priorities rather than organizational principles;

c. the current command and control structures within the CFMS hinder the DGHS/CO CFMG from providing corporate, strategic direction or leadership to the bulk of medical resources which belong to the environmental commands;

d. lack of unity of command by the HCC over resources providing in-garrison care impact the ability of the HCC to effectively administer the base health care facility and provide patient focused service; and

e. the existing mandate of the CFMS as provided for by the Op Phoenix concept is best served by the current structure, at this time.

Recommendations Related to Command and Control of Delivery of in-Garrison Care

2.134 It is recommended that:

a. the commitment of CFMG and Command resources in support of in-garrison patient care be stabilized. Service-level agreements between CFMG detachments, Command units and the HCC should be established to ensure minimum resource commitments in support of in-garrison care;

b. improvements to the delivery of in-garrison care be achieved in the immediate timeframe through administrative, procedural and staffing adjustments rather than structural realignment of the function;

c. the responsibilities, authorities and accountabilities for the provision of in-garrison patient care be clarified between CFMG staff, Command staff, Base Commanders and Health Care providers;

d. HCC responsibilities focus solely on the provision of in-garrison care for CF members and the operation of the health care centre. Operational and other CF related medical issues that were formerly addressed by the Base Surgeon pre-Op Phoenix should be addressed by Command medical staffs; and

e. consideration be given in 18 to 24 months to establishing a centralized health services organization.

HUMAN RESOURCE ISSUES

CFMS Resources, Establishment and Staffing

2.135 Inherent in the objectives specified at the outset of this review (para 1.4) are senior management's concern regarding the Canadian Forces Medical System's ability to meet the health care requirements of CF members. In order to address this issue, senior management has questioned whether resource reductions that have occurred over the past five years have had a counter-productive impact on the provision of health care in the CF, and whether the CF medical service is resourced adequately to meet the needs of service members today.[28]

2.136 Prior to the reengineering of the CFMS undertaken as Op Phoenix, the focus of the CFMS and its resources was on the delivery of day-to day health care support to the CF. First and second line medical resources assigned to environmental commands were organized in units to support operations, but were frequently double-hatted to provide in-garrison health care to the CF population at the respective CF bases or units where they were garrisoned. Third line resources were organized and structured for the most part to provide in-garrison care. Personnel, when available, were drawn from these garrison facilities to form operational medical components to support specific operations.

2.137 The Op Phoenix review fundamentally changed the roles and priorities of uniformed medical personnel. By all accounts, the CFMS could provide excellent in-garrison health care to the CF, but at the expense of developing the capability to support CF operations. Restructuring of the CFMS was proposed with the intention of making significant savings in the areas of personnel, infrastructure and health service delivery. Uniformed medical personnel were reduced from over 3000 positions to approximately 1800 positions which have subsequently been increased to 2071 as identified at Annex C. The concept proposed by Op Phoenix was to establish uniformed medical personnel to support operations and that ongoing operational and training requirements would not provide sufficient uniformed resources to fully meet the legislated requirements for in-garrison and hospital-based care.

2.138 In order to ensure the timely provision of in-garrison health services to the CF post-Op Phoenix, a small uniformed management cadre (the health care coordinator and an administrator) was assigned to co-ordinate the delivery of in-garrison health services. This was to ensure that essential maintenance and monitoring of the medical readiness of CF personnel would be maintained. Resources to provide in-garrison health services were to be obtained from operational and non-operational essential military medical personnel on an as-available basis and

[28] CANFORGEN 065/99 CDS 054 29 Jul 99, Special Message from the CDS.

civilian health care providers to provide services coordinated by the on-site HCC. It was acknowledged that any increase in operational commitments would result in a greater reliance on the civilian health care sector and contract personnel.

2.139 As a result of FRPs, Op Phoenix reduced the numbers of uniformed medical personnel significantly, and specifically those established to provide in-garrison care. Coincident with the reductions inside the CF, civilian medical schools were reducing their intake of medical students with a resultant decrease in production of civilian doctors. Over the same period (1994-1999) the Canadian Institute of Health Information indicated that there has been a national reduction of 3 per cent in the number of family physicians, along with overall restructuring of provincial health delivery services. As a result, the Op Phoenix premise of acquiring supplementary medical assistance from the public sector has not been entirely feasible. In addition, the attrition rate of GDMOs from the CF has risen to a level of 75 per cent to 80 per cent upon completion of obligatory service, as compared to the more traditional 50 per cent rate experienced in the early 90s. The impact of this situation can be seen in the following table indicating increases to CFMS budget expenditures from 1993/94 to 1998/99 which spans two years prior to the implementation of Op Phoenix and the three years following that activity.

Table 1

CFMS Expenditures

	93/94	94/95	95/96	96/97	97/98	98/99
Admin	$1,656,296	$2,176,178	$3,038,652	$4,068,428	$6,123,188	$5,020,669
In/Out Patient Care	$12,231,200	$11,961,376	$12,397,526	$13,815,528	$17,676,742	$19,956,363
Personnel	$10,909,247	11,052,216	10,643,936	15,932,809	14,090,475	17,821,707
Repair/Mtnce	1,237,777	1,130,656	995,757	839,031	705,419	764,616
Medical Supply	21,344,562	21,210,569	20,950,363	16,624,084	17,191,965	22,699,940
Gen Supply	1,472,918	1,716,805	1,585,766	1,012,120	1,141,117	514,566
Totals	**$48,852,000**	**$49,248,000**	**$49,812,000**	**$52,292,000**	**$56,928,906**	**$66,777,861**

Note: These expenditures exclude costs for dental services and military personnel costs. Personnel costs in this table are for the purchase of contract medical personnel only.

The increase in direct costs incurred for health care can be attributed to an increase in the purchase of 'in/out patient care' costs and costs for contracting civilian physicians to meet the CF in-garrison requirements. While these costs can be offset against savings that accrued in military personnel savings, the question remains whether the level of medical care to the CF member has been detrimentally impacted by the reduction in uniformed medical personnel.

2.140 Although uniformed medical personnel are established to meet the operational requirements of the CF, the provision of in-garrison care is dependent on the availability of CFMS staff. While CFMG and Command medical staff provide in-garrison support when they are available and their units are in garrison, the demand for in-garrison services does not

decrease proportionally when their unit is deployed. Those personnel requiring care remain behind, continuing to place health care demands on the CF medical facility. The premise that civilian medical resources would provide the necessary augmentation to military resources does not take into account the local availability of physicians willing to assume this role, the administrative delays in acquiring civilian services, and the relative efficiency and effectiveness of professional staff engaged under flexible work arrangements providing services to the CF. The consequent workload demands on the uniformed in-garrison health care providers has resulted in significant workload increases, stress and 'burnout' that, by their own admission, has affected their professional morale and attitude and influenced their ability to deliver care at a level they wish to provide. In the absence of workload statistics (ceased to be collected in 1994 with resource reductions), workload measures and performance indicators are not available for analysis to permit site-by-site redress of this issue.

2.141 The current distribution of medical personnel within the CF is as follows:

Table 2

Distribution of Medical Personnel in the CFMS

Chief Maritime Staff	Chief Land Staff	Chief Air Staff	CFMG	Other (trg)
110	723	304	917	265

This establishment and allocation of uniformed medical resources is based on operational requirements of the CF. However, in addition to meeting their operational requirements, the concept of Op Phoenix calls for uniformed medical personnel to be made available to supplement other arrangements for delivery of in-garrison health care, provide for military occupational medical needs and respond to domestic taskings that cannot be assigned to contract civilian personnel. In order to meet their in-garrison health care responsibilities, health care coordinators are dependent on the availability of CF medical resources.

2.142 Uniformed medical resources are outside the HCC's chain of command, and may become unavailable to provide in-garrison care due to deployment, pre- and post deployment training, continuing medical education (CME), medical competency training, leave or other justifiable absence. Lack of line authority over these resources creates problems for the HCC in clinic scheduling, workload balancing and finding timely replacement of uniformed resources with civilian personnel. This results in inconsistent levels of medical service to CF patients, contributes to poor continuity of care, delays in access to services and contributes to stresses on the caregiver and the patient. In addition, demands placed on the HCC to fulfil medical taskings assigned by the Base Commander which are outside the scope of in-garrison care, with resources over which he has no line control, only increases the demands on the CF medical facility and stresses their ability to deliver day-to-day in-garrison care.

2.143 In order to address this concern, two options exist to minimize the disruption to in-garrison care caused by a lack of line control over uniformed medical personnel in the CF medical facility. Firstly, minimum staffing requirements for MOs at each in-garrison site should be determined through site-specific workload analysis. These minimum staffing levels would be maintained by civilian practitioners through contract or other public service employment arrangements, with the CF 2058[29] process only being used for short terms or to meet urgent or extraordinary circumstances, as it was originally intended (see para 2.214). Secondly, formal service level agreements would be established between the HCC and Command and/or CFMG ensuring a commitment of uniformed medical personnel in support and under command of the HCC for defined or indefinite periods of time. This would guarantee the availability of health care resources for in-garrison care at the same level of priority as operational taskings.

2.144 When discussing establishment and resource requirements of the CFMS, a primary focus is on the medical officer (GDMO). The following table presents the establishment and actual strength of GDMO positions at the Capt/Maj ranks from 1996 to July 1999, with forecasts provided until 2002.

Table 3

General Duty Medical Officer (GDMO) – Establishment and Attrition Levels

Year	Capt			Maj			Total Shortfall
	Establishment	Actual	Shortfall	Establishment	Actual	Shortfall	
1996	136	116	**20**	48	46	**2**	**22**
1997	100	92	**8**	51	37	**14**	**22**
1998	100	97	**3**	51	33	**18**	**21**
1999	100	80	**20**	51	37	**14**	**34**
2000	100	69	**31**	51	27	**24**	**55**
2001	100	57	**43**	51	17	**34**	**77**
2002	100	36	**64**	51	7	**44**	**108**

Note: Capt and Major GDMO positions on Active Training List have not been included. Inability to fill positions on the Advanced Training List (for medical specialties etc.) would increase the shortfalls.

While the establishment for MOs has remained unchanged from 1997, the actual strength has declined by 21 positions or by 14 per cent between 1997 and Jul 99. Anecdotal evidence of workload, patient access and timeliness of service indicate the impact of the lack of available resources. With no workload statistics or performance standards for in-garrison care, it is difficult to objectively state whether this establishment is adequate. However, the shortfall of

[29] Para 2.214 describes the intended use of the CF 2058

manning to establishment and an attrition rate of 80 per cent after completion of obligatory service, indicate that attention to retention and recruitment strategies must be addressed before a judgement can be passed on the adequacy of the GDMO establishment.

Benchmarking CF Medical Resources to the Canadian Population

2.145 An additional perspective on the appropriateness of resource levels in the CFMS is a comparison of the establishment of general duty medical officers and specialists in the CF with the supply of physicians and specialist in Canada. The Canadian Institute for Health Information[30] reports that the number of people per physician in Canada has increased steadily since 1993. For much of the 1970's and 80's the rate of growth of physician supply exceeded population growth. The 1991 Barer-Stoddart report[31], whose recommendations were accepted by the 1993 Conference of Health Ministers highlighted this concern and, while refraining from prescribing an optimum doctor:patient ratio, presented recommendations to address "the mismanagement of a national resource". A combination of increasing population and a decreasing number of physicians has resulted in seven consecutive years of physician decreases relative to the population. In 1997, the number of physicians (general practitioners and specialists) in the civilian sector was 183 per 100,000 population, while the ratio of general practitioners alone was 93:100,000 population. Within the CFMS, the ratio of established positions for GDMOs (Med 55A) and Medical Specialists (Med 55B) in 1999 is 348:100,000.[32] The ratio of established GDMO positions alone is 252:100,000.[33]

2.146 While ratios do not adequately reflect the reality of patient access to and availability of in-garrison care (due to MOs involvement in uniquely military activities such as 'maintenance of competency' training and operational or field training, in-garrison management or the management and distribution of resources across the CF), they provide an indication that appropriate resource management and utilization of GDMO resources will yield greater benefits than increasing establishment positions that may remain unfilled. It must be acknowledged as well that the uniformed CFMS resources are also augmented by full and part-time contract physicians supplemented by the public health infrastructure, which provides even greater leverage to the number of CFMS resources which compare favorably to the availability of similar resources in the public sector. Without site-specific workload analysis, statistics, and determination of CFMS resource availability for in-garrison care to confirm the appropriateness of CFMS establishments, current resource levels of GDMOs compare favorably to the availability of general practitioners in the public health sector.

[30] Canadian Institute for Health Information, Supply, Distribution and Migration of Canadian Physicians 1997, Southam Medical Data base.

[31] Barer,M. & Stoddart,G. Toward Integrated Medical Resource Policies for Canada. Report prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health.1991

[32] The ratio for the CF has been converted from 209:60,000 to a standardized population of 100,000 for comparison purposes.

[33] The ratio for GDMO positions has been converted from 151:60,000 to a standardized population of 100,000 for comparison purposes.

2.147 A further benchmark of CFMS resource levels is in the area of specialist medical services. The following table indicates the CFMS establishment and actual manning of specialist positions, and provides approximate CFMS ratios to CF patients compared to Canadian public sector ratios of similar specialists.

Table 4

Medical Specialties - A Comparison of Ratios of the CFMS and the Canadian Civilian Sector

Medical Specialty	CFMS Establishment	Actual - 1999	CFMS Ratio to CF population	Canadian Public Sector Ratio
General Surgery	8	9	1:7500	1:16,535
Orthopedic Surgery	4	4	1:15,000	1:28,088
Anesthesia	8	8	1:7500	1:13,484
Internal Medicine	8	8	1:7500	1:5347
Psychiatry	6	5	1:10,000	1:8,284
Radiology	2	4	1:30,000	1:16,499

Source: CIHI Supply, Distribution and Migration of Canadian Physicians 1997

This benchmark comparison indicates that the CFMS establishment for some medical specialties compares favorably to availability in the public sector. However, these statistics should be considered in the following context. While some CFMS ratios compare favorably to specialties in the public sector, the Canadian public is clearly concerned about the availability of their health care resources. While CF members share a similar concern, the *relative* availability of some CFMS specialists exceeds those in the public sector and aligns with the requirement to meet the CF health care priorities of our operationally deployed forces.

2.148 One area of medical specialty to note is psychiatry where the ratio of CFMS practitioners compares less favorably with the public sector. Due to the nature of ongoing CF activities, heavy workloads and frequency of deployments, the incidents of socio/psychological cases are ever-increasing. These cases are placing a heavy demand on the in-garrison health system and the GDMOs who must meet these demands at the expense of providing general medical duties. While the CFMS has limited psychiatric resources at a time when there are increasing demands, it must be acknowledged that additional support resources are provided by the CFMS in the form of 33 uniformed social worker positions, contract socio/psychological personnel and the newly

established Operational Behavioural Sciences Centres, to augment psychiatric specialists. Collection and analysis of caseload/workload statistics will be essential to determine if the current resourcing in this area is adequate.

2.149 It must be acknowledged that a direct comparison of ratios between the CF and the civilian sector does not take full account of the distribution, management and utilization of CFMS medical resources or the level of care they are providing. As a result, the review team concludes that site specific workload analysis, statistics, and review of availability of uniformed medical resources at each health care centre is required to determine the appropriateness of current CFMS establishment levels. Critical to a review of appropriate resourcing is addressing the recruitment and retention strategies of the CFMS, as shortfalls in staffing and their resultant impacts does not necessarily indicate inappropriate establishment levels. The forecasted shortfall of GDMO resources to FY 2002 (Table 3) has a compounding effect on retention rates, development of future medical specialists, stress on the care-givers, and ultimately on their ability to deliver care at a level acceptable and appropriate to the CF patient. The impact of recent pay adjustments and incentives may have some impact on retention rates after completion of obligatory service in the short term, but any impact on recruitment will not become evident until recruits in the MOTP or MMTP become available after six years of medical training. While resourcing of positions is a critical concern of the CFMS, the number of established positions cannot be assessed as inappropriate without site specific workload analysis.

2.150 Reductions to CF resources in areas other than the CFMS have also had an impact on the provision of first and second line medical care and in-garrison health services. Current shortfalls in the medical assistant occupational category (Med 711) have been attributed to resource reductions in the CFRETS organization. The medical assistant MOC accounts for 1113 positions of a total of 2071 CFMS positions (55 per cent). Currently this MOC has a shortfall of approximately 300 positions (27 per cent of establishment). CFMG staff attribute this shortfall to a lack of training capacity for this trade rather than a shortage of applicants. While the resource reduction has taken place in a peripheral organization, the impact is directly felt within the CF health care environment. This shortfall will reverberate throughout the CFMS as the medical assistant trade is the "feeder" organization for other specialist health services occupations[34] such as operating room technicians, medical laboratory technicians etc. which comprise a further 11 per cent of the CFMS.

Funding

2.151 During the course of this review, the sentiment was expressed to the review team that the amount of healthcare provided to the CF patient population was viewed as a function of the financial resources that were made available to the CFMS. While there has been no evidence that medical care or treatment has been denied based on cost, the possibility of such circumstances occurring has been anecdotally expressed through interviews and patient focus groups.

[34] Operating Room Technicians, Medical Laboratory Technicians, X-Ray Technicians, Preventative Medicine Technicians, Bio-medical Technicians, Health Services Technical Managers and Aeromedical Technicians.

2.152 The current funding process for health care to the CF originates with the CFMG's spending proposal in its business plan which is included with the ADM(HR-Mil)'s annual budget submission. Upon approval, budgets are distributed to DGHS/CO CFMG with spending authority delegated to Command Health Advisors, Formation Health Coordinators and subsequently to base and wing Health Care Coordinators. Commands do not provide resources specifically for medical services except discretionary augmentation of CFMG-provided baseline funding for in-garrison support.

2.153 The focus of funding concerns appears to be in the area of meeting unforeseen spending requirements. The requirement for additional health care expenditures by the local manager (HCC), is reflected in the forecast of additional expenditures in the mid-year review – submitted as a request for supplemental estimates by DND in Oct/Nov and receives approval by Parliament in December. These funds are distributed to CFMG and then to local managers. However, the interim costs after the October timeframe must be met through internal transfers of funds. This process and apparent delay in funding has created an impression, particularly with inexperienced health care centre managers, that if funds are not available at the outset of a commitment period, they cannot be assured and may be considered unlikely to arrive. This has created an atmosphere of uncertainty which has been interpreted by the staff and patients, that health care in the CF is 'cost-driven' and that decisions on care and treatment would be based on availability of funds. In reality, CFMG has been able to meet all additional requirements for health care funding. In order to avoid confusion and impressions which can fuel sentiments of mistrust or lack of confidence of members in the CFMS, local managers need to be better informed of the CFMG funding process, which should remain transparent to the delivery of healthcare to the CF patient.

Staffing and Leadership

2.154 The actual delivery of in-garrison health care in accordance with the established CF spectrum of care and standards is the responsibility of the Base Commander and the Health Care Coordinator. Medical officers with clinical backgrounds have traditionally filled the HCC positions. These positions ideally require skilled health care professionals with management and leadership abilities who are capable of developing innovative in-garrison health care delivery models, operating the CF facilities in an efficient and cost-effective manner, and ensuring that quality health care services are available to support CF members on behalf of the Base Commander. However, HCCs frequently receive little training or experience for the management role that they are required to assume. Because of the blurring of authorities and responsibilities between CFMG HQ, formation Commanders and their requirements, and the Base Commanders, the HCCs are more apt to wait for direction to come from medical channels on management issues, rather than independently take the necessary action required to address local issues. The HCC position as defined by Op Phoenix, does not have a long history with defined methods of operation, mature networks with the public sector health community, established precedents or an experienced cadre of HCCs to provide guidance and mentoring as to how best to meet the intended objectives of the position. HCCs charged with the responsibility to coordinate and ensure the provision of in-garrison care, are generally young and inexperienced

managers, largely due to the high attrition rate of GDMOs. In the past, Base Surgeons worked closely with Command Surgeon staff thereby providing a valuable level of supervision. These positions are now remotely located at NDHQ, and no longer available to provide supervision and mentoring which would be beneficial to the present cadre of HCCs. These circumstances indicate that the HCC position would benefit from increased managerial training and assistance specifically to manage the HCC function as intended in the CFMS restructuring. At a time when significant shortfalls are forecast in the availability of GDMO positions to provide in-garrison care, consideration should also be given to increasing the involvement of the health care administrator/health services officer in the role of management activities in the HCC, while optimizing the availability of GDMOs for in-garrison clinical duties.

2.155 The provision of health services to CF members is provided or coordinated by various elements of the Canadian Forces Health Services branch both in peacetime and during operations. The Director General Health Services (DGHS) is the senior advisor on health service issues for the CF, and is responsible to coordinate those activities related to the provision of health care support. This position is the senior staff officer on health issues for the CF. Currently, this position is also assigned the responsibilities of the Commander, Canadian Forces Medical Group.

2.156 Historically, a military medical officer chosen from within the medical branch has held this position. In addition, this position currently holds the appointment of the Surgeon General for the CF. The Surgeon General is considered as the senior health care physician. DGHS is responsible for health care doctrine, health care standards and policies, and the management of CF health programs. Military medical officers who have held this position in the past have come from a variety of employment and training experiences. However, aside from being a physician, there did not appear to be a unique set of qualifications required to be selected for this post.

2.157 The majority of the senior positions in the health services branch at the NDHQ, formation headquarters and base level are assigned to medical officers. This is also the case for the Commanding Officer positions for most medical units. Members holding these positions come with a variety of different qualifications and background experiences in either the clinical and/or management areas of the branch. However, being a physician has generally been the unique qualification required for selection.

2.158 Over the past years, due to reductions in the size of the CF, and due to periodic shortfalls within the medical officer classification, medical officers selected to fill these positions were frequently lacking in management training and experience. Prior to the Op Phoenix review of the CFMS, the focus of most military physicians was in the provision and/or coordination of in-garrison health care services.

2.159 This management pool within the medical officer occupation has been further weakened by higher than average rates of release from the CF. This often has resulted in rapid promotions to management positions by medical officers with limited management or leadership qualifications for these posts. Regardless of what changes were made to the organizational structure as a result of Op Phoenix, there has continued to be a large number of medical officers dominating the senior management positions within the CFMS.

2.160 This issue was addressed during Op Phoenix. The establishment of a new Health Services Officer (HSO) classification to fill generic command, managerial and staff positions at the senior officer level addressed the need to provide greater career advancement opportunities for health care officer classifications other than medical and dental. Furthermore, the qualifications developed for the classification would ensure that HSO officers received the training and experience necessary to be militarily effective and credible. HSO officers were to be drawn from existing health care feeder classifications, namely Health Care Administration (HCA 48), Pharmacy (Pharm 54) and Nursing (Nur 57). An occupational transfer to the HSO classification would not be approved until a successful applicant had achieved professional military and managerial qualifications and had completed at least one tour of duty in the major rank in his or her feeder classification. The HSO MOC would commence at the rank of major and progress to colonel. The feeder occupations were to be capped at the rank of Major.

2.161 During the initial staff checks conducted for the overall organizational structures for the new Health Service Branch, a significant number of senior positions were established as HSO positions. However, during this process, many of these positions were earmarked as also open to be filled by a qualified medical officer. As the process evolved, the number of senior HSO positions was gradually reduced and additional senior medical officer positions were created. Movement in this direction is considered to be contrary to the recommendations proposed by Op Phoenix and reduces the effective utilization of medical personnel possessing managerial expertise.

Qualifications for DGHS Position

2.162 An issue of concern within the CFMS community is the requirements and qualifications that should be established for the DGHS position. Ideally, the DGHS should have a solid background in military health services. At a minimum, this should include the same level of military command and leadership training required of all other CF officers of the equivalent rank. He or she should be experienced in senior command and management functions and have held positions where this capability was demonstrated. Experience in operational health planning and delivery is essential. Training and work experience in health care management and business planning are also key functions of the DGHS position. In addition to the above requirements, a solid clinical background would provide the ideal candidate.

2.163 DGHS must be a visionary capable of establishing a strategic direction for the CF medical system, a consensus builder and a keen decision-maker. He or she must be capable of steering the Health Services Branch along in step with the remainder of the CF. Commitment to

the delivery of quality health services and support to operationally deployed troops and units, as well as in-garrison health care to CF members is paramount. He or she must be a business planner capable of thinking outside of the current health delivery environment. He or she must be committed to operating an operationally oriented and cost-effective health care delivery system. He or she must be capable of dealing with a variety of health professionals to facilitate partnering the CFMS with the public sector health care community to ensure optimum performance at all levels, and be capable of representing all of the professions which comprise the CFMS.

Selection Criteria

2.164 The criteria for the selection of the DGHS should be no different than that used to select other senior appointments within the CF. Members from all health care officer classifications who have pursued the appropriate career paths to aspire and progress to this position, should be eligible for selection which should be based on the most qualified and experienced officer available at the time of selection.

2.165 The appointment of Surgeon General for the Canadian Forces should remain with the senior physician within the organization. However, there is no logical argument to support this appointment being tied to the position of DGHS. This appointment should be held by the DGHS if a physician fills the position. When a member of an occupation other than a physician holds the DGHS position, the appointment of the Surgeon General could then be given to the clinician in the next most senior physician position.

2.166 The review team consulted extensively on the issue of whether someone with expertise other than that of a medical doctor could be the DGHS and/or Surgeon General. The feeling expressed from within the CFMS community is that the Surgeon General must be an MO. It is implicit in the title that this individual is an MO. For reasons of credibility among colleagues in the international military medical community alone, it is appropriate to have the Surgeon General as a medical officer. However, the individual occupying the DGHS position does not necessarily need to be Surgeon General as well. Accordingly, the pros and cons of making such a change need to be weighed in the context of appropriately manning the CFMS to suit the circumstances of the day. While the CEO of civilian hospitals is frequently a health care administrator, this individual is normally supported by a medical advisory board comprising a group of physicians. When the CF is considering comparing its management structure to that of health care facilities in the civilian sector, it is important to take account of inherent similarities and differences in the nature of the business of providing health care in the civilian sector and providing it in the CF.

2.167 Many of the pros and cons for making a change from the traditional position of having an MO as DGHS were presented to the review team by both doctors and HSOs – Some doctors argued that DGHS could be an HSO and some HSOs were adamant that the position should remain as a doctor. As well, there was a full spectrum of views in between. The fact that some doctors openly supported the concept of DGHS being an HSO dispels the myth that *this is not a viable concept because no doctor would be willing to work under an HSO.* As well, *the notion*

that making DGHS an HSO would cause attrition to accelerate and deter recruitment may also be a myth. Doctors work in the civilian sector for health care organizations that are not headed by a physician, so why is this different from the CF? If there was a marginal resultant increase in attrition it would be a single event, after which time the command and control structure of the CFMS would be known.

2.168 Consideration to select the DGHS position should not be restricted or limited to the CFMS. In the short term, as the era of transition is continuing to unfold in the CFMS, selection of a candidate to fill this position could include a health care professional either internal or external to the CF, who possesses the qualifications, managerial experience and business skills to successfully implement the concepts, objectives and principles of Op Phoenix and serve as the basis for the way ahead for the CFMS. Knowledge, experience and linkages which would assist forging the necessary partnerships with the public health care sector should also be factors in determining the qualifications for this position.

Conclusions Related to CFMS Resources, Establishment and Staffing

2.169 The review team has concluded that:

a. the provision of in-garrison health care services remains highly dependent on the availability of CFMS uniformed personnel. Arrangements with the public health care sector have not yet matured to meet the objectives envisioned by Op Phoenix;

b. workload and case load statistics and data are not being gathered to permit analysis to determine minimum staffing requirements for both uniformed and civilian health care providers;

c. a decrease in the number of physicians relative to the Canadian population has severely impacted the availability of and access to the public sector health care sector by the CF;

d. the ratio of the number of general practitioners and medical specialists (established positions) to the CF patient population, generally exceeds the ratios of similar occupations in the civilian sector;

e. attention to management and utilization of medical specialist resources, including staffing currently unfilled positions will yield greater benefits to the provision of in-garrison services than increasing the number of established positions;

f. the distribution of a CF population over a wide geographical area (coast to coast), may negate the benefit of having more favourable ratios of medical professionals to patient population than exist in the civilian sector;

g. the CFMS capability to provide health care services is augmented by accessing services in the civilian sector, thereby increasing the leverage of a dedicated CF medical service;

h. shortfalls of personnel in the CFMS do not equate to insufficient established positions;

i. current shortfalls in the medical assistant occupational category will have a future impact on those medical specialist trades which draw on the medical assistant occupational category;

j. health care coordinators are lacking managerial and administrative training specifically to manage the HCC function;

k. at a time when significant shortfalls are forecast in the availability of GDMOs to provide in-garrison care, greater involvement of the health care administrator in the role of managing activities in the CF medical facility would optimize the availability of GDMOs for clinical duties; and

l. there is insufficient consideration of command leadership experience in the selection of candidates to fill senior management positions in the CFMS.

Recommendations Related to CFMS Resources, Establishment and Staffing

2.170 It is recommended that:

a. workload, caseload and other performance measurement data be gathered at all CF sites providing in-garrison medical care;

b. existing established CFMS positions be staffed before additional positions are authorized for the respective MOCs;

c. strategies be developed to address current shortfalls in the medical assistant occupation;

d. a two-pronged strategy be pursued to address managerial deficiencies in the CF medical facilities;

(1) HCCs be given appropriate management training before assuming the position and on-going training while they are in the post; and

(2) HCAs and HSOs located in the CF medical facilities assume more of the administrative responsibilities related to delivery of in-garrison care, thereby freeing up clinical practice time of the health care coordinator.

e. position analysis statements of senior positions in the CFMS be examined by appropriate staffs to determine the skill sets required to perform the prescribed duties of the respective positions.

Recruitment and Retention of Medical Officers

2.171 It is clear that GDMOs and specialist MOs are leaving the CF at a faster rate than they are entering. What is particularly alarming is that there are lower levels of interest in programs such as the Medical Officer Training Program where the member's training is paid for by the CF, in addition to salary compensation while in medical school.

2.172 In the past, high turnover of GDMOs was an accepted cost of doing business in the military and the benefit was that the CF was receiving young, energetic medical school graduates who were recently trained to a provincial standard on the latest techniques for delivery of medical care. While they did not have the same experience levels as those who had been practicing medicine for several years, they were as experienced as their colleagues entering the civilian market, at the same time, and were about to treat a relatively narrow age band of a healthy population.

2.173 With other doctors in the training pipeline the fact that most GDMOs only stayed for 4 or 5 years was not viewed by the CF as a major problem. As well, sufficient numbers were staying to fill the hierarchy in the more senior administrative ranks. Today the situation is quite different. The projected outflow of military clinical physicians is now exceeding inflow to the point that shortfalls at the Captain/Major level are now projected as follows:

Table 5

Projected Shortfall GDMO Captains/Majors

YEAR	1999	2000	2001
CAPTAIN/MAJOR SHORTFALL	34	55	77

2.174 With net attrition projected at rates which would generate the above shortfalls, and given that it takes 4 or 5 years from when the medical student enters the pipeline until they are available to practice medicine, the CF has two strategies available to them to address the shortfall. One strategy is to increase the number of direct entry officers (DEOs) primarily through the use of an incentive scheme and the second is to slow down the outflow of uniformed MOs (i.e., improve the retention rate).

2.175 The Department has examined the DEO issue and developed a strategy intended to attract licensed medical doctors to join the Regular Force for a four year period in return for a one-time $80,000 recruitment bonus, in addition to a competitive salary. The level of interest that this offer generates remains to be seen, but it is expected to be attractive to recent graduates who will likely find the one time lump sum helpful in retiring debt accumulated during the period that they were in the education system.

2.176 Assuming that the DEO strategy is effective, the other side of the equation that must be addressed is the outflow or retention issue. During our field visits the review team sought interviewee input to get a sense of the issues that were causing members to leave after completion of their compulsory service and to determine if changes could be made to encourage more members to stay in the CF. There are some site specific as well as more generic reasons cited for the higher attrition rate. The following is a listing of some of the dissatisfiers that were identified by the MOs:

a. a significant change in the role of the GDMO in recent years from one of providing mainly in-garrison health care services to more of an operational orientation;

b. provincial licensure requirements have impacted GDMOs who are posted from province to province, from easily participating in medical activities outside of the CF. Employment as a GDMO within the CF has immediate and long term implications for their medical careers;

c. in order to stay active in the provision of clinical medicine, doctors must decline promotions after the rank of major effectively capping their careers and restricting salaries to future inflation adjustments. MOs pointed out to the team that for those who studied medicine to be clinical practitioners, the CF discourages them from pursuing a long term career in the forces;

d. there are limited opportunities and career restrictions for GDMOs who want to pursue medical specialties, particularly if they are not operational specialties required by the CF;

e. salary parity with civilian practitioners is a concern of GDMOs and specialists. Recent salary adjustments have addressed those concerns for the immediate timeframe;

f. GDMOs expressed concern over lack of attention paid to human resource management issues specific to their classification; [35]

[35] Cardwell, Mark . The Medical Post, Canada's Military Facing Doctor Shortage, 23 February 1999
"...Unfortunately there is little leadership or career management in the Canadian Forces. In four years I had one phone call and one meeting to talk about my concerns, what I wanted, or what it would take to get me to stay..."

g. GDMOs are concerned with maintenance of competence and CME opportunities they receive. Opportunities are inconsistent across the country, poorly monitored, often leaving them ill-prepared for situations they may face when deployed on operations. MOs expressed concern that they were uncomfortable working in the CFMS where they may be placed in a position to provide services for which they are not fully medically competent; and

h. MOs expressed the sentiment that their efforts and contributions were not valued by the organization or the patient population. This had impacted on morale, job satisfaction and commitment to the CF.

2.177 As stated at the beginning of this report, the review team has noted significant interrelationships between issue areas and fixing one problem can have a ripple affect in addressing shortcomings in other areas. The above is a list of some of the dissatisfiers for doctors and provides a basis of understanding of why they want to leave the CF. However, if some of the dissatisfiers were to be addressed, the CF could focus more on patient care and the needs of the soldier rather than investing significant time, effort and money on strategies to attract new recruits and stem the flow of those who wish to leave.

Conclusions Related to Recruitment and Retention of Medical Officers

2.178 The review team has concluded that:

a. as the attrition rate for MOs is significantly higher than historical averages, at the same time as little interest is being expressed in traditional entry venues (Medical Officer Training Program), the CFMS will be facing significant military physician shortages over the next several years;

b. the CFMS has a strategy for attracting direct entry officers and is implementing it; and

c. there is no specific strategy being pursued to retain CF medical officers, yet MOs have a range of concerns that could be addressed to make being an MO more attractive.

Recommendations Related to Recruitment and Retention of Medical Officers

2.179 The review team recommends that:

a. the effectiveness of the bonus that has been put in place to attract DEOs be assessed periodically. If it is determined not to be meeting the objective then it should be reassessed and alternate strategies developed;

b. strategies be pursued to ensure an equitable sharing of deployment assignments among GDMOs and specialist MOs;

c. the CFMS represent or otherwise support CF MOs in discussions with various provincial and territorial medical licensing bodies on an as required basis on matters unique to serving CF medical officers (licensing issues, maintaining billing numbers etc.);

d. with the assistance of expert consultant support, the CFMS undertake a study to determine appropriate ways of encouraging clinicians to make a career of practicing clinical medicine with the CF;

e. a validation of the training being provided to MOs be completed to ensure that:

(1) MOs are receiving sufficient and appropriate maintenance of competence and CME to meet their operational and in-garrison responsibilities, and

(2) complete training records are maintained and available to leaders who will be taking decisions on the deployment of MOs (trauma, burns, geriatrics, pediatrics etc.); and

f. the CFMS leadership examine ways to increase the profile of the contribution of MOs in the CF.

Morale, Attitude and Capacity for Change in the CFMS

2.180 Health care within Canada has experienced a decade of upheaval in the 90's. It has been fraught with political turmoil, restructuring activities, increasing health care costs, spiraling infrastructure costs, changes within the medical profession and patient care issues. The Canadian Forces Medical System has not been immune to these events and has made significant efforts to respond and adapt within this context of change. These efforts have not come without an impact on the personnel working within the CFMS and their patients. As a result, morale and professional attitudes of both the health care workers and the recipients of their services have been impacted. These factors have an influence on the capacity of the CFMS to adapt to further changes and carry out the necessary implementation action that was initiated with the Op Phoenix review.

2.181 The overall morale and attitude of CFMS personnel as, they impact on the provision of in-garrison care, was assessed through the extensive interviews, focus group discussions and questionnaire polling conducted by the review team. Morale of the individuals and the organization as a whole, was a topic of significant interest on which many members expressed very passionate views. The following paragraphs present a summary of the sentiments expressed by both providers and recipients of in-garrison care and the perceived impact on the quality of care provided.

2.182 When medical staff of the CFMS were asked if they found working in the CFMS personally frustrating, 63 per cent agreed or strongly agreed that this was the case.[36] The frustrating aspects of being a health care provider in the CF were attributed and ranked in the following order:

a. difficulty in meeting the competing demands of delivering in-garrison patient care while expecting to maintain occupational competence;

b. striving to meet the competing demands of what is best for the patient while meeting the needs of the chain of command;

c. working in an environment where low morale is a common phenomenon;

d. meeting high patient expectations rooted in the past with the use of today's resources; and

e. the difficulties in receiving continuing medical education.

2.183 In addition to these factors affecting the morale of members working within the CFMS, the following themes were expressed to the review team. CFMS staff in leadership roles both at NDHQ and at health care centres, indicated that their staff are "demoralized and feel that they are not receiving any recognition for the good work they are doing while a few high profile cases receive considerable attention." It has been stated that the professional cadre within the CFMS is "fed up with change" and that they are looking for tangible changes to be put into effect which will improve the provision of care to the patient and enhance ongoing work conditions of the health care provider. Eighty percent of medical staff felt that the CF makes 'less than an acceptable effort', to 'no effort at all' in considering their career needs. Seventy-one percent of the staff felt that the CF was 'unsuccessful' to 'very unsuccessful' in offering career opportunities within the medical MOCs.

2.184 When asked if they could provide better medical care than they are presently able to deliver in the CFMS, 69 per cent of the CFMS medical staff felt they could provide better care. Particularly frustrating for the health care workers was the administration that supports them in the provision of medical care. Seventy-five percent of CFMS staff felt that administration related to the delivery of medical services 'fell short' to 'considerably short of meeting the needs of CF members'. A significant source of frustration for the health care workers which impacts their morale is that 94 per cent felt the CFMS (the providers of that care), receives criticism

[36] Staff also reported that there were many rewarding aspects to working in the CFMS (namely providing a high standard of care to CF members, saving lives of those who have chosen to serve their country, and the training aspects of a CF medical career).

when it is other elements in the chain of command or administrative issues with a strong medical component (such as temporary medical categories) that do not fully meet the expectations of the CF member.

2.185 When asked if the current level of morale in the CFMS 'influences the way in which I carry out my clinical duties', 65 per cent of respondents indicated it influences 'to some degree' or 'strongly influences' their provision of care. It was apparent throughout the fact gathering stage of this review that CFMS staff at all levels (including MOs, nurses, medical assistants and technicians) were experiencing a high degree of personal and professional frustration to the point where they felt patient care provided by CFMS resources was being impacted. This significant erosion of morale has occurred over the prolonged period of reengineering and renewal of the CFMS without any foreseeable improvements accruing to the caregivers. Compounding the sentiments already expressed, are the inherent frustrations of the complex command and control relationships governing in-garrison care. Being held accountable for delivering in-garrison care but not being responsible for the resources (para 2.152), has resulted in additional personnel management and administrative frustrations for the in-garrison care providers.

2.186 CFMS staff have also indicated that they have been so embroiled in OP Phoenix implementation activities, organizational transition and defence of the resultant organization, that patient care issues have not received the attention they deserve. While many operational commanders and CF patients have not yet come to accept the current approaches to CF health care, the providers of care find themselves unfairly placed in a position of explaining a health care system which many played little or no part in developing.

2.187 From the CF members' perspective, there is a general sentiment of a lack of trust and confidence in the CFMS to take care of their in-garrison health care needs. The provision of in-garrison care has been undermined by the general sentiment that this function is being provided by CF resources only until resources are drawn upon to respond to higher priority operational demands. Implementation of OP Phoenix strategies, Departmental/CF reengineering and restructuring initiatives have all resulted in changes to delivery regimes for in-garrison care which have not been well communicated or explained to the patient population. Many long-serving CF members had become accustomed to a legacy of in-garrison health care delivery which has been drastically altered without obvious direct personal benefits to the member. Perceived unfulfilled expectations of health care service, coupled with changes to service delivery methods that have not been well-communicated or well-supported by clear and efficient administrative processes have contributed to a sentiment that their personal health care needs are not being well attended to by the CFMS. When these factors are coupled with having their health care needs delivered by a visibly stressed and demoralized professional staff, the result has been widespread general sentiment of lack of confidence and trust in the CFMS to meet their in-garrison health care needs. The pending implementation of initiatives such as 'embedding of patient care' in civilian hospitals and 'designated provider plans' does not offset the perceptions of current in-garrison care which have been influenced by high profile incidents or personal experiences which become well-known by the patient population.

2.188 Sentiments expressed by CFMS staff and the CF patient population are also mirrored in the views held by CF commanding officers and supervisors. Polling of focus groups of commanding officers and supervisors indicated that 87 per cent felt the level of concern the CF has for meeting the medical needs of its members falls 'somewhat short' or 'considerably short' of meeting the needs of the CF member. In addition, 74 per cent felt that the level of effort that the CF invests in order to meet the health care needs of CF members as 'low' or 'extremely low'. Such a sentiment held by military staff is not lost on CFMS personnel who must continue to perform their function in light of such criticism of their efforts.

Ethical Issues

2.189 During the conduct of this review, members of the CFMS, CF patients and commanding officers/supervisors have all raised ethical issues or concerns that influence the provision of in-garrison care. The existence of these ethical issues impacts the morale and attitude of the professional staff who provide health care services and the trust and confidence of those members in receipt of the service or who must rely on the service to ensure they are able to meet their operational goals and objectives.

2.190 GDMOs delivering in-garrison patient care must function within the Base command and control structure. As a result, MOs reported both at interviews and review focus groups, that it was often difficult to exercise medical judgements independent of the demands and expectations of senior commanding officers. In particular, GDMOs at the lower ranks indicated that they were often subjected to silent and cultural pressures to serve the needs of the commands and the objectives of the CF in an environment focussing on operations, reduced resource flexibility and the requirement 'to do more with less'. MOs indicated they faced significant professional ethical dilemmas when balancing the well-being of the patient, the needs of commanding officers, and the needs of the CF as an employer. Polling during focus group sessions indicated that 85 per cent of MOs experienced the chain of command having taken action (either occasionally or more than several times a year) which affected a CF member that was not in accordance with the recommendations of a medical officer. This situation occurred particularly in the administration of temporary medical categories, where 57 per cent of MOs felt that their recommendations for assigning temporary medical categories were not respected by the chain of command.

2.191 This perspective of the MOs was also reflected in the views held by commanding officers and supervisors who indicated (71 per cent 'agreed' to 'strongly agreed') that it was necessary to influence the medical practitioners in matters related to patient care in order to meet the operational needs of the CF. CF members receiving health care from the CFMS also expressed views that the medical system was inappropriately used by the chain of command for other than its intended purpose. Examples were presented to the review team where temporary medical categories were used as a mechanism to deal with difficult personnel administrative issues rather than using the appropriate administrative procedure. Similarly, strong sentiments were

expressed that criteria for assigning temporary medical categories with career implications were not uniformly applied to all rank levels, thereby further eroding trust and confidence in the medical system.

2.192 Implementation of the embedding concept, which places CFMS staff in civilian hospitals to provide medical services to CF and civilian patients and to obtain 'medical occupational competency' training, has removed a structure of monitoring and supervision that is normally present within the CF environment. While these initiatives exist to serve well-stated objectives, they have provided opportunities for individuals that have not always been in the best interest of the CF, or provided benefits that are not equally shared by all members of the CFMS. As a result, the integrity of the CFMS may be placed at risk, further eroding trust and confidence in the medical service. There is a need for guidelines which will ensure the maintenance of a CF ethos, proper monitoring and supervision of training activities and adherence to CF regulations and policies for all staff involved in this innovative approach.

Capacity for Change in the CFMS

2.193 During the fact gathering phase of this review, it was made clear to the review team that members of the CFMS are suffering low morale, dissatisfied with the status quo of their profession in the CF, and feeling disenfranchised by their leadership. Organizationally, personnel have lost a sense of belonging to a CF health care community due to the disparate chain of command and the absence of clear corporate strategic direction for the ongoing management of the health care function. A sense of commitment to the CFMS is being eroded as professional medical staff see their colleagues leaving the CF as soon as their obligatory service is completed – creating a sense of abandonment and leaving more work for those remaining. The CFMS is an organization plagued by 'change fatigue', heavy workloads, and a sense of personal frustration trying to satisfy competing organizational and professional responsibilities while attending to personal career aspirations.

2.194 The question arises whether the CFMS, given its present state, is capable of devising the needed strategies and mobilizing its resources to take the necessary implementation action to carry out its mandate on behalf of the CF. A discussion of **New Initiatives**, later in Part 2 of the report, indicates that there is a range strategies either in place or about to be put in place to address structural gaps and shortfalls that are present in the in-garrison health care system. However, the successful implementation of these steps is dependent on the critical application of CFMS skills, resources, knowledge, effort, experience and commitment. Each of these attributes in the CFMS have been challenged during the last decade, particularly since the completion of the Op Phoenix review. Members of the Branch are not convinced that the CFMS and departmental leadership is committed to a corporate strategic direction, with clearly established goals and objectives for providing in-garrison care. The relative isolation of the Branch from mainstream CF activities and decision-making has tended to organizationally marginalize health care and has subordinated medical staff to other CF staff functions.

2.195 CFMS staff have expressed the sentiment that personnally and professionally, they have already made the necessary efforts and commitments to sustain delivery of health care during recent years of restructuring and transition. They have paid a high price in terms of stress, burn-out and attrition which has resulted in serious concern about "care for the caregiver".

2.196 It is apparent to the review team that there is little reserve capacity remaining amongst the cadre of CFMS staff. There no longer remains the option for further program experimentation, dramatic change initiatives, or seeking additional contributions from Branch staff. It is of paramount importance that all levels in the CF, particularly the CFMS, demonstrate a commitment to health care issues and the personnel who manage and provide that care. Tangible management efforts must be directed at the ongoing delivery of clinical care to the CF member, the career concerns of all CFMS MOCs, and the objectives of the Branch. Unless all levels of command and leadership take an active interest in the provision of health care services, it is questionable whether the CFMS organization will have the capacity to bring about further implementation efforts. As well, the CFMS should not be expected to pursue further change on their own. Assistance will be needed to steer through the challenges that remain ahead.

Conclusions Related to Morale, Attitude and Capacity for Change in the CFMS

2.197 The review team has concluded that:

a. low morale exists in the CFMS on a widespread basis, and is negatively impacting the attitudes of health care personnel in the clinical setting;

b. reasons for low morale are varied and include but are not restricted to:

(1) change fatigue being felt at all levels of the CFMS,

(2) lack of understanding where the organization is headed strategically,

(3) CFMS personnel sensing a lack of appreciation or understanding from the CF of the demands that have been placed on them,

(4) a perception that the corporate focus on health care has shifted from patient care to the task of implementing Op Phoenix,

(5) leadership concerns within the CFMS, and

(6) heavy workload, including in-garrison and operational responsibilities, to which there appears to be no end in sight;

c. some personnel have expressed the view that they no longer have the reserves to continue to do their jobs and to cope with further change initiatives. While there are significant initiatives yet to be implemented to strengthen the provision of in-garrison care, the success of these initiatives will be dependent on the capacity of the CFMS health care professionals who must implement the changes necessary for the long term benefit of the CF.

Recommendations Related to Morale, Attitude and Capacity for Change in the CFMS

2.198 It is recommended that:

a. an assessment be made of the amount of assistance that will be required to enable implementation of the recommendations of the CRS review; and

b. the Department support the requirement, once validated, with appropriate financial and human resources.

OTHER MANAGEMENT ISSUES

2.199 This section of the report will address several management issues that surfaced during the review and were determined to impact on the delivery of in-garrison care. The section will include the administration of in-garrison patient care; mechanisms for backfilling MO positions; mechanisms for securing specialist services; provision of first responder care in-garrison; migration of ideas; and information management/information technology in support of CF health services.

Administration of In-garrison Patient Care

2.200 A recurring theme that emerged during focus groups and interviews was that patients regard administration as a critical aspect of in-garrison patient care. The CF member tends to take a holistic view of his or her medical care which is not restricted to the specific care provided, but rather includes: the making of the appointment; the efficiency and effectiveness of the doctor patient interaction - whether or not the doctor spent the appointment time consumed in filling out forms or was there time for appropriate clinical procedures and discussion to take place; how well patient records were administered or managed; whether or not the patient was appropriately directed while in the CF medical facility; whether or not when the member left the facility he or she knew what were the next steps and who would be responsible for making arrangements for those steps.

2.201 The preceding paragraph highlights a number of basic procedural matters that were identified for the review team as being important to the patient yet did not consistently function as intended. When the systems did not serve the patient well his or her perceptions of care being received by the CF diminished. During focus group sessions when patients were asked if their interaction with the CFMS met their expectations only 44 per cent or less than half agreed or

strongly agreed. In follow-on discussion patients indicated that its was the break down or failure of some of these basic administrative processes that eroded their personal satisfaction with the CFMS.

2.202 Making of the Appointment. As members pointed out, the operational nature of their work, even when in-garrison, is not consistently conducive to easy access to telephone services or transportation to and from medical facilities. Accordingly, the member needs a simple process for making appointments with the base clinics/health care centres and needs to be able to count on those arrangements having been made. As well, whether for follow-on appointments at the base clinic or referrals for specialist consults, the member is looking for uncomplicated processes that will secure time with the physician without posing an excessive administrative burden on the patient.

2.203 Efficiency and Effectiveness of the Doctor/Patient Interaction Time and Related Administrative Deficiencies. This is an area that was a concern for patients and doctors, and although solutions are administrative in nature there are also continuity of care matters to consider. From the patient's perspective, he or she is interested in receiving the clinical attention while at the appointment and not spending inordinate amounts of time watching the doctor deal with excessive numbers of forms. Similarly, doctors expressed frustration to the team when excessive amounts of clinical time had to be invested in filling out forms. While doctors recognized the need for the forms and that a certain amount of clinical information had to be recorded, it was the 'tombstone' type information (name, rank, service number, unit etc.) that was particularly frustrating to record numerous times on various forms. While some base medical facilities made health cards available to members with this information embossed, much like on a standard credit card, others did not.

2.204 The impact of not having such basic processes in place is that not only is the doctor/ patient time inefficiently used, but also a highly manual process of completing forms is prone to errors that result in misdirection of lab results, loss or misfiling of patients records, erroneous provision of medical information to patients etc.

2.205 Administration and Management of Patient Records. As discussed earlier in the report under **Continuity of Care**, a strategy that the Surgeon General supports in order to achieve a degree of continuity of care is the maintenance of good medical records. While there are likely many cases where soldiers' files serve as comprehensive records of patients' medical histories, a significant number of instances were brought to the team's attention where patient files were lost or test results or other records were missing from the files or blocks of the members' medical history could not be found on patient files.

2.206 The CFMS has policy guidance[37] on the administration related to patient records. While the policy addresses how files should be transmitted, and issues of confidentiality outside the CFMS, details on how the file is handled within the CFMS are sketchy at best. No reference is made to CFMS protocols related to patient file handling (signing for files, what positions/MOCs are authorized to access patient files etc.). Given the sensitive nature of patient information, the review team has concluded that lack of specific guidance on the handling of patient files leaves too many opportunities open for files to be mismanaged or mishandled.

2.207 The review team was advised that at most CF sites Med As, on temporary assignment from an OTU, field ambulance or other organizations not in the chain of command of the HCC, are responsible for the handling and administration of patient files. Given the high turnover of Med As flowing through the base clinics, as a result of the current high tempo of operations combined with the 300 member Med A shortfall, there is little continuity in the administration of these files. As well, the review team was advised that, in the past, Med As received medical records management training in a class room setting, as part of their trade course curriculum at CFB Borden. As a consequence of the downsizing of CFRETS, medical records training is now restricted to a self-study course that Med As do outside of the structure of the class room environment.

2.208 Attending to Patients' Administrative Needs While at In-garrison Medical Facilities. The review team was advised from a range of sources that administration, particularly at the larger health care centres is not always as strong as it could or should be. Cases of individuals being given incorrect information or unable to obtain information regarding where to go for lab tests, x-rays, arranging for specialist appointments etc. were brought to our attention. While these circumstances exist, in part, due to the high turnover of medical personnel flowing through these facilities it also indicates that appropriate site orientation is not consistently taking place. When members are given misinformation or cannot readily obtain information from inside the medical facilities that are serving them, the levels of confidence and trust in the system are eroded and take time to be regained.

2.209 Mechanisms, Processes, Facilities for Dealing with Extraordinary or Unusual Patient Circumstances. On several of our field visits and during focus group sessions, the review team was told of circumstances where commanders or the base clinics had to deal with medical situations that were unusual and neither fit well within the new 0800 to 1630 concept for base clinics or the civilian system. The types of cases that were brought to the review team's attention are indicative of a civilian system that is at times operating at capacity yet is one that the CF is now heavily reliant on in the in-garrison setting. The types of situations that are arising include members receiving minor surgery in civilian hospitals then being released back to their units when a degree of home care is required. When the member lives in barracks this poses unique difficulties in providing varying levels of home care.

[37] Canadian Forces Medical Order 5-2, Medical Records, CH21 1984 - 07 - 28

2.210 Another situation is a member threatening to commit suicide. Cases were reported of individuals who were assessed as requiring 24 hour supervision, yet not sufficiently ill to be accommodated in the civilian mental health system. A third situation cited was an individual in early stages of an as yet undiagnosed degenerative disease. The individual is unable to drive, cook or otherwise provide for him or herself, but is not considered ill enough to be evacuated to a hospital which is three hours away by road. There is no longer a base hospital available to provide the care. In each of these situations the CF used to be able to accommodate most of these short term situations using the CF hospital network. Without these systems any longer in place other innovative approaches need to be found. While each case was managed by the units, through application of extraordinary measures, the situations provided cause for concern for the involved COs and patients who were left with the impression that changes to in-garrison medical care and reduced capacity of the civilian sector have left members and COs questioning the CF commitment to looking after the soldier, sailor and air man or woman.

Conclusions Related to the Administration of In-garrison Patient Care

2.211 The review team has concluded that:

a. patients take a holistic view of their medical care which includes the administration associated with it;

b. CF patients who experience poor administrative practices when receiving in-garrison medical care frequently interpret those problems as poor medical care being provided to the member;

c. not all health care centres have reasonable records management tools in place (Bradma Plates or equivalent) to reduce administrative workload and minimize opportunities for error;

d. lack of internal policy and procedural guidance on the handling of patient files has left CF in-garrison units with very wide latitude in this important process;

e. given the sensitive and very personal nature of medical information it is necessary that protocols be in place for the handling of patient files within the CFMS;

f. the high turnover of medical personnel flowing through the CF medical facilities, particularly Med As who are responsible for the administration and management of the files, has the potential to negatively impact on how files are managed;

g. placing greater responsibilities on the student for learning patient record management through self-study rather being trained under the guidance of an instructor has increased the risk that the Med A may not cover all of the material or, if they do, may not understand it all. While this may be an economical way to deliver the training, it may be less effective and this would never be known without an appropriate validation process;

h. patients administrative needs are not consistently provided for when visiting CF in-garrison facilities leaving members with a poor impression of the CFMS and consequently eroding their confidence and trust in the system serving them;

i. medical situations are arising that are not being readily provided for by either the CFMS or the civilian medical system;

j. while these issues may arise due to local circumstances that exist at a particular time similar problems are surfacing in multiple locations; and

k. while workable (not always ideal) solutions are generally found, the more that HCCs know about how others have handled similar situations, the better placed they should be to respond appropriately when required.

Recommendations Related to the Administration of In-garrison Patient Care

2.212 It is recommended that:

a. CF health care centres examine their internal administrative functions and processes to ensure that:

(1) such basic information management tools as Bradma Plates or equivalents are in place, and

(2) other mechanisms for streamlined processing of in-garrison patients are in place and functioning as intended;

b. the CF policy and procedural guidance on handling of patient records be made sufficiently clear and complete so as to provide an appropriate level of protection for the documents, provide a reasonable degree of assurance of the integrity of the information contained therein and provide assurance to the member that their medical information is being adequately safeguarded while in the custody of the CFMS and civilian medical service providers;

c. standard operating procedures be put in place and kept up to date at all CF medical facility sites to assure consistent high quality administration supports the delivery of in-garrison medical care;

d. HCCs track medical incidents that have arisen that cannot be accommodated through CF in-garrison patient care arrangements or the civilian system. These incidents should be advised to Surgeon General for his/her information; and

e. sharing of how these experiences were handled should take place at forums where HCCs are brought together with migration of ideas being one of the objectives of the session.(more discussion on this concept is included later in Part 2 of this report in the **Migration of Ideas** section).

Mechanisms for Obtaining Civilian Physician Services In-garrison

2.213 HCCs have been given the responsibility of providing in-garrison care through the base/wing/formation level CF medical facilities across the country, yet no longer have military resources (doctors and medical assistants) within their chain of command to provide the service. An acceptable administrative process to obtain these services through the civilian sector was not put in place before the dedicated military resources were struck from the establishments of the CF medical facilities.

2.214 HCCs have been providing the in-garrison medical care by temporarily using the services of civilian doctors hired on short-term contracts (DND 2058) and military MOs that have been loaned from CFMG operational units, field ambulances etc. As a result HCCs have been expected to provide a full time medical service (although the hours of most health care centres have been reduced considerably) with a very unstable professional labour force. Due to inadequate administrative arrangements having been made to obtain professional services from the civilian sector, extraordinary measures have had to be made within the CF cadre of MOs, including recalling members from leave, canceling military leave and working personnel excessive overtime hours, in order to provide the service.

2.215 In analyzing why it has been difficult to secure the services of civilian medical doctors to support in-garrison patient care, the phenomenon is attributable at least in part to the administrative process being used to obtain those services. The DND 2058 is the mechanism that was reported to the review team to be used across the country for contracting the services of temporary civilian medical personnel. This abbreviated contracting process is attractive to the HCC from the perspective of avoiding the complexities of a more traditional bidding process, and hence can facilitate the expeditious filling of a temporary position. It can also be attractive to a physician who is looking for short term work and happens to be readily available.

2.216 The DND 2058 form is intended to be used for short term civilian physician engagements or to meet emergency requirements. Civilian physicians engaged through this process to practice medicine in the CF in-garrison setting are frequently receiving back to back contracts for extended periods of time. This is not the way the DND 2058 contracting process was intended to be used.

2.217 The following are two significant downsides to not using the DND 2058 as intended:

a. the risk in completing these renewals (in some cases over periods of several years) is that this process could be in conflict with the Public Service Staff Relations Act; and

b. it is difficult to attract a stable cadre of civilian physicians willing to commit to a long term service delivery arrangement, even on a part time basis, when the most the CF is willing to commit to is six months at a time through this tenuous contracting arrangement.

2.218 Most civilian contract doctors interviewed pointed out that they found many aspects of working in the CF in-garrison setting to be very appealing. Some of the appeal comes from dealing with relatively healthy adult population which can be professionally challenging, but not onerous work; hours are regular, with little weekend work; for those who are not interested in trauma medicine, most CF clinics no longer have emergency department services; no marketing/ patient solicitation responsibilities due to the captive audience provided by the military; and no office management responsibilities as these are attended to by the HCC and his/her health care administrator.

2.219 Accordingly, through the way the CF is administratively approaching the contracting of civilian physicians it is threatening what could otherwise be a favourable arrangement for both the physician and the CF and running the risk of drawing criticism from central agencies for inappropriate hiring practices.

Conclusions Related to Mechanisms for Obtaining Civilian Physician Services In-garrison

2.220 The review team has concluded that:

a. the decision to realign the CFMS organization structures to support a more operational focus without having systems in place to backfill MO positions with contract civilian physicians has placed an enormous burden on HCCs responsible for the delivery of in-garrison patient care;

b. this burden has in turn been passed on to military MOs who have not only had to respond to the demands of an increased tempo of operations, but have also had to make further personal sacrifices to ensure that patient care continues to be delivered in garrison (recalled from leave, leave cancelled, MO on TMC supposed to work half days working 12 to 14 hour shifts etc.); and

c. use of stop-gap measures for contracting civilian doctors has become a matter of routine in most CF medical facilities, in most cases is unfair to the contract physician and contravenes accepted public service hiring practices as provided for in the Public Service Staff Relations Act. For many CF medical facilities the DPP (discussed in greater detail later in this Part of the report under **New Initiatives**) is not scheduled for implementation for sometime.

Recommendations Related Mechanisms for Obtaining Civilian Physician Services In-garrison

2.221 It is recommended that:

a. the Surgeon General with the support of the CF, progress implementation of the DPP at CFMS in-garrison medical facilities across Canada as expeditiously as is reasonably achievable; and

b. pending implementation of the DPP, CF sites providing in-garrison care review the appropriateness of continued use of the DND 2058 form when engaging temporary civilian physicians. If a more appropriate mechanism cannot reasonably be put in place before inception of the DPP, then HCCs should, at the very least, advise civilian doctors currently on contract with the CF that the DPP is coming and what the implications of that change could mean for them.

Securing Specialist Services for Delivery of In-garrison Care

2.222 The CF is experiencing varying degrees of difficulty in obtaining the services of civilian specialists to provide in-garrison patient care to military members, depending on the region in Canada where the service is being sought and the nature of the specialty required. Matching the supply of doctors and patient demand is clearly a national problem in the civilian sector as well as in the military. In areas where certain medical specialists are in short supply some organizations have taken extraordinary measures to secure more timely health care for their clients. The Workman's Compensation Board for the Province of Alberta, for example, has proposed that although its members are covered by the provincial health care insurance system, it is willing to pay a fee to purchase more timely services from physicians operating outside of the provincial plan. Public backlash has ensued as this creates a two-tiered health care system that essentially provides a more timely service for those who can pay and pushes those who can't pay further back in the queue.

2.223 Some interviewees suggested to the review team that comparable arrangements be made for CF members. One argument offered to the review team for preferential treatment being given to CF members is that the work that they do is in support of the peace and security of their country and a certain level of medical fitness is necessary in order that they can do their jobs. The opposing view would be that, as a Canadian citizen, the CF member should be entitled to the same care as a civilian, but that he or she should not be entitled to anything that would exceed that care. Most interviewees acknowledged both sides of the argument.

2.224 Rather than wading into the arenas of these two opposing views and risking departmental/CF exposure to the potential negative political and media attention that could result, the review team offers two less controversial alternatives. One option would be to make an assessment of average patient demands for particular specialty services and make *block purchases of physician and/or operating room time*. The approach could be regarded as a form of insurance for the CF and if the services were not fully utilized each month those circumstances would be regarded as merely a cost of providing in-garrison medical care for an operationally ready force. A second approach is *trans-regional treatment*. Under this concept, on a case by case basis, a decision would have to be made that certain non-emergency cases required higher priority service than could be offered in their garrison regions. The health care coordinator network could then be used to find which region in the country had the shortest queues for the required specialty and if the difference were appreciable the military patient's name would be added to the civilian queue. The intention would be to transport the patient to the region where the service is available, have the procedure performed then transport the patient back to his or her garrison region as soon as practicable to complete their recovery.

Conclusions Related to Securing Specialist Services for Delivery of In-garrison Care

2.225 The review team has concluded that:

a. as a general practice, it would likely not be appropriate for DND/CF to be seen to be jumping the civilian sector queue by sending CF members to fee for service health care providers; and

b. there are strategies that could be pursued in order to obtain specialist services quickly under extraordinary circumstances. Two sources are through purchasing blocks of physician time and trans-regional treatment.

Recommendations Related to Securing Specialist Services for Delivery of In-garrison Care

2.226 It is recommended that:

a. statistics be gathered and analyzed to determine areas where the CF generates unusually high numbers of cases requiring certain specialty care from the civilian sector. Where regular patterns exist and there is difficulty securing that care then arrangements should be made to purchase block amounts of physician time; and

b. in non-emergency situations, on a case-by-case basis, assessments be made to determine if extraordinary steps should be taken to secure specialist care for the member, outside his or her geographical posting area, on a more timely basis than could be provided locally.

Provision of First Responder Care In-garrison

2.227 The CF currently provides first responder medical services at most CFBs across the country through the use of fire services personnel or a combination of fire services personnel and medical personnel. In locations where proximity of the CF site requiring service is close enough to an appropriate municipal service, arrangements are sometimes made with local civil authorities to provide first responder care.

2.228 While provision of first responder care is not a medical responsibility of the CFMS per se, it is a quality of life issue that has medical implications for the service member. Concerns relating to first responder care were expressed to the team from the fire service as well as medical personnel who may be called upon to assist. From the fire service perspective, this is a responsibility that has been assigned to them largely as a result of the reduced scope and hours of service of former CF hospitals and this is a traditional role for fire fighters in civilian communities. The former CF hospital facilities have been mainly reduced to clinic status and no longer provide services in emergency trauma medicine. While most of the fire service personnel have been provided training at various levels in basic St. John's Ambulance First Aid, Advanced First Aid and CPR, this training has not been provided uniformly across the fire service.

2.229 The fire service has concerns about the extent of responsibility it has for provision of first responder care. Should it include provision of service to dependants as well as CF members? To what extent should CF in-garrison medical facilities be called upon to assist in first responder care? At one site there is a Med A assigned to the fire hall to meet just such emergency medical care requirements. At another site the capability has been developed to the point that the CF is actually providing a first responder service to the civilian population on the base and in the local community, and receives a grant from the municipality for doing so.

2.230 Health care coordinators are unclear, at some sites, as to the extent to which their in-garrison resources are to be drawn upon to assist in first responder care. Med As on assignment in some of the CF medical facilities are frustrated because they are not being called upon to assist in first responder calls that occur on the base or in the wing, although they feel well-qualified to perform such a role. As CF medical facilities and the base fire hall both fall under the jurisdiction of the Base Commander local arrangements have been made largely in response to the wishes of the local leadership.

Conclusions Relating to Provision of First Responder Care In-garrison

2.231 The review team has concluded that:

a. while first responder care is a peripheral issue for the medical services branch, the fact that confusion exists among those responsible for provision of in-garrison care makes it an issue that could impact the level of patient care provided the soldier, sailor and air man or woman; and

b. the Surgeon General has a responsibility to provide medical advice to the CDS on the adequacy of the current arrangements for the provision of first responder care. He should be able to tell the CDS if the CF member is receiving first responder care that is equivalent to that being received by the average Canadian and, to the extent that it may fall short, the degree of increased risk for the member.

Recommendations Relating to Provision of First Responder Care In-garrison:

2.232 It is recommended that:

a. Surgeon General be prepared to offer medical advice to the chain of Command, including Base Commanders, on matters related to the delivery of first responder care in-garrison;

b. as part of the staff assistance visits to CF in-garrison locations the Director Health Services Delivery include the adequacy of first responder care as an area to examine. Recommendations resulting from such assessments should serve as a point of discussion with the Base Commander, the Health Care Coordinator, Fire Chief and any local authorities that might be impacted. Appropriate actions should result based on the direction of the Base Commander; and

c. communication be issued at the base/wing/formation level explaining the local arrangements for delivery of first responder care.

Migration of Ideas

2.233 Migration of ideas is an area that has proven in the past to pose significant challenges for DND and the CF as organizations have tried to renew and reengineer themselves. During the course of this review the team found that, like other areas of the Department, the CFMS has difficulty sharing ideas generated from within. Discussions of organizational issues in earlier sections of this report point out a rather insular organization that comprises both organizational and career/professional stovepipes that can both serve as impediments to the migration of ideas.

2.234 The combination of stovepipe organizations, and professional and support trade/ skill groups does not contribute to an environment that would be naturally conducive to sharing of ideas. This phenomenon, coupled with personnel geographically spread across the country, and at times the world, poses a significant challenge for leaders and managers who need to exploit the creativity of their people and inspire the generation and propagation of innovative ideas throughout the CFMS.

2.235 The first CFMG HQ staff assistance visits (SAV)s[38] were about to be conducted at in-garrison CF medical facilities across Canada at the time of writing the first draft of this report. Particularly where continuity of personnel assigned to those teams can be maintained, there are several benefits related to migration of ideas that have the potential to accrue from the SAVs. Some of the benefits are listed as follows:

a. teams can be building a library of best practices from each site;

b. teams can be building a library of the most common weaknesses in CF medical facilities to be able to provide general cautions to the CFMS in areas where problems could surface if appropriate proactive measures are not taken; and

c. during their closing interview with the HCC at the end of the site visit SAV teams could highlight areas from their best practices library that are particularly relevant to that that site. This could include providing a contact name at a site where the SAV observed the best practice functioning with the intention of facilitating implementation.

2.236 During the review team's visits, field organizations frequently showcased information technology-based local level initiatives. While there will be more discussion on this area in the next section of the report, it was noteworthy that a particularly high level of enthusiasm and excitement existed relating to some of the data base applications, that had been developed at the various sites, and were in use in support of the delivery of in-garrison patient care. When asked if the developers had had the opportunity to share their ideas with colleagues the answer was invariably and categorically, 'no'.

2.237 As the bulk of the CF's GDMOs have traditionally come from the MOTP and, hence, are at the beginning of both their careers with the military and their profession of practicing medicine they are on a steep learning curve. As well, many only complete their four years of compulsory service then leave the CF. Accordingly, it is particularly important for this group to benefit from the experiences of others in order that they may make a most effective contribution to the service in the short time that they are in the CF.

[38] The background behind the SAVs and recommendations for improvement to the current concept are provided under the New Initiatives section which appears later in this Part of the report.

2.238 With the high attrition rates that the CF has experienced in recent years it is not unusual for doctors, at early stages of their careers, to be promoted to the rank of major/lieutenant commander and assume full responsibility for the delivery of in-garrison care at the base/wing/formation level. The CF cannot afford to have HCCs learning everything on their own, repeating mistakes made by others before them, and missing out on leveraging on the ideas of their colleagues.

Conclusions Related to Migration of ideas:

2.239 The review team concluded that:

a. there is little opportunity within the CFMS to readily share innovative ideas and solutions that would contribute to the efficient and effective delivery of in-garrison health care;

b. CFMS personnel are generating good ideas, particularly ones relating to data base management of patient information, and are putting those ideas into place at some sites. Sharing of these IM/IT ideas offers the opportunity for leveraging on ideas that have already been developed; and

c. the sharing of ideas will not occur on its own, but will require a deliberate effort in order to derive maximum benefit from this concept.

Recommendations Related to Migration of Ideas:

2.240 It is recommended that:

a. CFMS personnel ensure that, when setting up training programs, workshops, conferences or other forums where branch members will be brought together, that some time is set aside for sessions where sharing of ideas could take place; and

b. the Staff Assistance Visit (SAV) capability that has recently been stood up in the Assistant Chief of Staff Health Services Delivery (ACOS HS Del) be utilized to the fullest extent possible as an impetus and catalyst behind the migration of ideas across the CFMS.

Information Management/Information Technology Support to CF Health Services

2.241 The CFMS does not currently have an integrated information management or information technology system. For the most part, day-to-day health information is gathered and managed in a paper-based environment. Several individual units and sites have developed and implemented varying degrees of information technology capabilities which are usually word processing or spreadsheet formats developed locally to address specific needs or requirements. However, there is very little standardization or information management capability within these systems, with no

centralized management reporting capability. Some of these stand-alone systems are labour intensive to establish, and although they have benefits that accrue to individual units, they perpetuate the long standing problem of stovepipe systems across the CF. In the long term, when a corporate health care IM/IT system is developed, there may be some organizational resistance to abandon local systems which have been developed, received internal commitment and proven to work well to meet their specific needs. However, due to the mobility of CF members, the need to obtain and share health information with all of Canada's provincial health systems and our allies during deployment, a commitment to an enterprise-wide IM/IT health information system is essential.

2.242 In light of the impact of health issues on the CF and the requirement to have real-time knowledge of the health status of operational units to support operational roles, the CFMS does not have adequate IM/IT systems to support this requirement. The mobility of the CF population, increases in operational deployments, increased reliance on civilian health care providers, difficulties being experienced in managing manual health records and the requirement to manage a standardized quality of health care delivery at all CF sites, reinforce the need for an integrated health information system to support the CFMS. The CDS, in his presentation before SCONDVA concerning the fourth pillar in the Quality of Life Dimension (Care of Injured Personnel, Veterans and Retirees) stated that: "We must provide all sick or injured personnel with consistent and comprehensive care while serving, after release, and on retirement." In order to implement this statement, it is incumbent on the CF to ensure that comprehensive and accurate health information captured on a CF member spans their entire career, must be readily available at all levels, both in operational and non-operational environments, during a member's career and after release.

2.243 Currently, operational commanders and care providers do not have ready access to timely and accurate information concerning the health status of their personnel. Health care managers at all levels have insufficient data on which to base decisions concerning the effective and efficient allocation of health care resources and limited information is available for strategic decision-making. Other NATO countries and the civilian health services sector are making progress in developing systems to provide for the accurate and timely provision of health information to their health care providers, patients and decision makers. However, the CF is falling behind and may experience difficulty in sharing health information with civilian providers and with NATO allies. Inadequate and insufficient management tools at both the national and base health facility level and the inability to share and effectively use health information, has resulted in a labour intensive yet limited approach to managing health services. Care providers at the local level do not have access to clinical decision support tools that can provide information concerning the most appropriate treatment regime to follow or to recommend CF clinical practices. The absence of IM/IT tools also contributes to the already heavy workloads experienced at CF health facilities and impacts the ability of CFMS health care professionals from efficiently managing health services provided to the CF members. Current management systems present extreme limitations in tracking personnel or the medical treatment they may have received during deployments or from the public health sector, or the tracking of particular immunization programs, disease patterns or other specific health issues.

2.244 Currently, the CF Medical Service has a separate major medical IM/IT project in development (Project G2800). This system is being developed following the guidelines of the Federal Government Advisory Council on Health Infostructure which encourages the improvement of "patient care by creating provincial and territorial person-based, electronic health record systems. These (systems) will make accessible…all relevant information about (patients') past medical histories, including conditions and diagnoses as well as treatments and medications."[39] The goal of Project G2800 is to "provide an information management capability that provides the right information to the right person at the right time, thereby enhancing CF operational effectiveness and continuously improving the quality of care and overall health status (of the CF)"[40].

2.245 The IT system envisioned under Project 2800 is to support the current health care delivery model and management practices of the CF. At the present time however , a clear and consistent CFMS model is not in place and clinical practices at health care facilities remain in a state of flux as Health Care Coordinators struggle to establish linkages with their local health care community, to clarify command and control relationships for in-garrison resources and to determine appropriate health care centre operating procedures and practices. The proposed IM/IT system will attempt to capture all health information related to care provided to CF members and establish an electronic health record to support individual patient management capabilities. In the past, the CF was able to acquire most of the health information related to the care provided to CF members from CFMS health care providers and facilities. However, greater reliance on the civilian health care sector, private practitioners, specialists and medical technologists (laboratory etc.), makes developing the capability to capture data in a compatible format an ever increasing challenge.

2.246 The IM/IT solution to support the CF Health Services for the future, Project G2800, is targeted for FY2008 completion. It is currently in the pre-development phase with Enterprise Architecture Planning (EAP) scheduled to commence immediately. Although a target completion date is given as FY2008, considerable interim progress is being made within practical limitations. Contract award and the development of an initial operational capability for a CF Health information System is to be completed by December 2000. However, reengineering of CF in-garrison clinical practices prior to automation, integration with all Canadian provincial health information systems, establishment of communication and security standards for health records, and the iterative evolution of information management in the civilian health care sector are only some of the issues that will impact the long term 'roll-out' of a comprehensive CF health information system.

[39] Final report, Canada Health Infoway (Feb 99).
[40] Project G2800 Information Briefing to IMAC 24 Feb 99.

2.247 Any IM/IT health information system developed for the CF must have the flexibility to adapt to changes in healthcare delivery in the military and civilian health care communities. Historically, medical IM/IT projects implemented internally have been extremely slow in both their development and implementation phases, and usually result in the system being somewhat out of date by the time implementation is completed. At the present time, there are no fully functioning health services IM/IT system based on an electronic patient health record. However, it is acknowledged that the benefits of striving for such a system are compelling as the current procedure of manually extracting relevant patient information from traditional medical charts is inefficient and expensive. While better health care information is required for strengthened support to operations, enhanced health care of CF personnel, improved effectiveness and efficiency of care delivery and better access to health care information, the CF in-garrison health care delivery model has not been adequately established or refined to facilitate development of an IM/IT infrastructure. Premature development of an IM/IT system could result in major capital expenditures developing a system that is obsolete by the time it is implemented.

2.248 Health Information Security Issues Because the CF historically provided the bulk of health care for its members at CF facilities, it was accustomed to having virtually all the clinical and occupational health information to assess the members' health status. Civilian health care providers legally cannot disclose detailed personal health information without either the consent of the patient or a court order. With the current reliance on the civilian health sector, the CFMS must clearly define the specific type of information they require and develop a system-wide mechanism to gather this information. The basis of the CF member's electronic health record should focus on supporting occupational health decisions, and move away from the comprehensive approach of collecting all clinical information. During the Op Phoenix review, the idea of capturing only information that would impact on a member's long-term level of medical fitness and that which was required to determine disability entitlements was considered. The thinking at the time was that 'health information capture' and the electronic health record was required to support the CF occupational health requirements. Information acquired through the payment of patient health claims would provide data on where care was provided and type of services rendered. Efforts would be directed in acquiring only that information required to support occupational health decisions. A data-gathering system based on these premises would, in all likelihood, receive the support of CF members on the release of personal health information as it would assist them with any disability claims made during their career.

2.249 Health information within the context of the CF security regulations has been designated as "Protected B" and has been safeguarded accordingly within CF health care facilities. However, with more and more of the day-to-day health care requirements of the CF being provided outside of CF facilities, the transmission and handling of information to and from external sources causes a break in this internal security designation for health information. When primary health care services are provided to CF members outside of CF facilities, access to that information will prove difficult. While there are industry standards established for the handling of health information in the civilian sector, they are not compatible with the CF security designation, posing a problem with transmission of information to and from civilian health care providers. To address this issue, a realistic security risk assessment should be conducted to

ensure that a feasible and efficient integration of CF and civilian health information systems can be achieved to facilitate ongoing development of a CF-wide integrated CF medical information system.

2.250 During the early implementation phase of Op Phoenix, the CFMS ceased to collate, synthesize and analyze a plethora of workload and performance data associated with the provision of CF medical services. As a result, the ability to make management and resource allocation decisions based on performance management /measurement data has been constrained. The availability of health care information which is trusted, consistently available and useful for decision making is essential to support the provision and management of health services in the CF.

Conclusions Related to Information Management/Information Technology Support to CF Health Services

2.251 The review team has concluded that:

a. the CFMS does not have an adequate IM/IT system to provide real time knowledge of the health status of its operational units to support operational roles;

b. an integrated health information system is needed to support the CFMS due to the high mobility of the CF population, operational requirement for the health status of the CF, increased reliance on the civilian health care sector and the requirement to manage a uniform quality of health care delivery at all CF sites;

c. the CF in-garrison health care delivery models have not been adequately established and refined to facilitate the development of a CFMS IM/IT infrastructure;

d. increased integration between the CFMS in-garrison and the civilian health care sectors raises security issues as the CF has higher security standards for health information than the civilian sector; and

e. the ability of the CFMS to make appropriate management and resource allocation decisions has been constrained by the lack of available health care data, and workload volumes and statistics.

Recommendations Related to Information Management/Information Technology Support to CF Health Services

2.252 It is recommended that:

a. the in-garrison health care delivery model be established and be put in place to determine the necessary IM/IT support that will be required;

b. the CF develop policy related to acquiring, handling and release of health information for CF members both internally and externally;

c. the information requirements to support CF occupational health requirements be determined, along with the methods on how this information will be acquired and controlled;

d. the CFMS update and streamline business and management practices currently in use in order to streamline administrative processes and improve handling of patient information in the clinical setting;

e. CFMS business practices be adapted to take advantage of commercial off-the-shelf health care software applications to reduce design and development costs and facilitate integration with civilian health care providers;

f. plans be progressed to implement IM/IT solutions to support the CFMS that can be quickly put into place with the flexibility to meet changing requirements and conditions in both the CF and civilian health care sectors; and

g. a security risk assessment be conducted with regard to CF health information to facilitate the necessary links to the civilian health care sector.

NEW INITIATIVES

2.253 Despite the problems and shortfalls identified and discussed in this report, there are several new initiatives that the CFMS has begun to implement and anticipates will result in significant future improvements to the provision of in-garrison care to the CF. The following is a discussion of those initiatives and identification of some factors that should be considered which will improve their probability for success.

Staff Assistance Visits

2.254 By way of background, in the Spring 1998, the Surgeon General recognized that in moving towards a more operationally focussed force and in drastically cutting his headquarters staff he no longer had the level of involvement that existed in the past in the delivery of in-garrison care. He also recognized that although his involvement in the delivery of in-garrison

care was much less than it had been, there was still a requirement for a degree of oversight by the CF professional branch responsible for strategic and policy direction for health care being delivered to all members.

2.255 Accordingly, in the fall of 1998, the Assistant Chief of Staff Health Services Delivery (ACOS HS Del) was stood up with the responsibility to provide, among other things, oversight to the delivery of in-garrison health care. By early Spring 1999, ACOS HS Del had drafted and obtained CFMG Executive Council approval of terms of reference for a Health Services Review Committee (HSRC) which would be charged with reviewing the delivery of in-garrison care in the field through CFMG conducted staff assistance visits (SAV)s.

2.256 While the committee comprises some 20 positions/trades within and outside the CFMS, members' participation is largely as a secondary duty and only a subset of this group would actively participate on any particular SAV. CFMG staff envisage conducting 1 SAV per month for the first year, with teams comprising 5 to 7 members, depending on the site, and drawing primarily from the spectrum of skills represented on the HSRC. The composition of teams for the various sites will vary depending on the site to be visited and availability of personnel who will have to be taken away from their primary jobs in order to perform this function.

2.257 In principle, the CRS review team is strongly supportive of this initiative. With the autonomy that now exists for the CFMS in the field, loss of oversight that used to reside in the former command surgeon positions, the shift in focus towards operations brought about by events leading up to Op Phoenix and a new consciousness on quality of life issues for the soldier there has never been a more appropriate time for a SAV capability for in-garrison health services delivery than there is now.

2.258 One concern regarding the conduct of the SAVs is the resourcing of this capability. Staff specialists participating on the SAVs will do so as a secondary duty, thereby limiting the continuity of staff and hence some of the potential benefits of this endeavour. One such opportunity is discussed in an earlier section, **Migration of Ideas**, where the SAV could serve as a catalyst in support of the migration of good ideas across the CFMS in-garrison facilities. As well, if the bulk of the team is made up of individuals for which participation on the SAV is a secondary duty, there will be a some risk of last minute cancellations, on the part of team members, which could negatively impact on the effectiveness of the visit or result in actual visit cancellations. A third draw back to having the SAVs conducted as a secondary duty is the inefficient functioning of the team. Increased ramp up time for each visit, inefficient application of time while at the sites and lack of availability of personnel after the visits to appropriately document and report on what was found, are all high risk factors that could result from too many floating team members. A fourth draw back to inconsistent SAV team membership will come in tailoring and adjusting the review checklists. Team continuity would greatly facilitate identifying what is important to examine and what is not, and to making those adjustments to the review program that are most appropriate based on the seasoned team's experience.

Conclusions Related to Staff Assistance Visits

2.259 The review team has concluded that:

a. the staff assistance visit (SAV) capability is a critical one and deserves Surgeon General's strongest support; and

b. as currently structured organizationally, the SAV teams are at risk of being considerably less effective than they could otherwise be with a more stable membership. This stable membership is particularly important in the first few years of the SAV capability when the teams themselves are determining how their skills can be applied to maximum effect while in the field.

Designated Provider Plan

2.260 The Designated Provider Plan (DPP) is a mechanism that is intended to significantly improve delivery of in-garrison health care to CF members. It is a four component plan that will fill a major void existing as a result of the incomplete implementation of Op Phoenix.

2.261 The four key deliverables of the DPP are intended to:

a. develop a central mechanism to process invoices related to the purchase of health services and to develop some capability of promulgating management reports for decision-making purposes;

b. establish a formal off-site provider network to ensure no gaps in services and to provide a framework for negotiating favourable rates and conditions;

c. provide an improved mechanism(s) to back-fill on-site uniformed providers; and

d. establish a CF Health Information Line (1-800 Call Centre) to improve access to care by CF members regardless of availability of CF providers.[41]

2.262 An advantage to taking DND's current approach to the DPP is leveraging on the experience of some arrangements already in place with Veterans Affairs Canada (VAC). As well, the review team was advised that the Royal Canadian Mounted Police (RCMP) will also be partnering in this three-way venture. The original agreement with VAC is for an initial five year period. As previous inter-departmental initiatives with health care implications have yielded mixed results (such as the Health Care Co-ordinated Initiatives for Dental and Vision Care with

[41] Karpetz, LCdr H. Project Manager - Designated Provider Plan, Designated Provider Plan Update Briefing to DGHS Council, 12 Apr 99

Corrections Canada and other government departments), the CRS review team advocates maintaining some flexibility, particularly over the long term, as a good business approach to be taken by the CFMS.

2.263 The review team views the DPP with guarded optimism. The plan will be more attractive in certain locations and less so in others. As stated at the outset of this report, regional differences mean that a one-size-fits-all solution does not always work across the country and a degree of tailoring at the various sites will likely be necessary. On the other hand, the DPP offers the potential to smooth some of the regional differences in delivery of in-garrison care by placing administrative functions in the hands of one central authority. If the contractor can take some of the administrative burden away from the HCCs, then they in turn should be able to get back to focusing on patient care.

2.264 The DPP is not intended to be a cost-saving measure, as in certain remote locations it will be expensive to implement. However, the intention of the DPP is to provide a more consistent and uniform in-garrison health care service with improvements to service delivery.

2.265 At the time of writing of this report, the various pieces of the DPP were at different stages of approval and implementation. The MOU between DND and VAC to put in place billing arrangements through Blue Cross was signed-off by the appropriate parties in June 99 and is currently targeted for implementation 1 Apr 2000. Of concern to the DPP project office in CFMG HQ was the procurement/contracting aspects of putting in place the Call Centre and making arrangements for the on-site service providers. As communication materials are being put together, including patient health cards, which make reference to the Call Centre which is advertised to be open for business 1 Apr 2000, the review team was advised that procurement/ contracting arrangements need to proceed without delay.

Conclusions Related to the Designated Provider Plan

2.266 The review team has concluded that:

a. successful implementation of the DPP will fulfill the objectives as set out by the Op Phoenix implementation plan;

b. the DPP is intended to relieve HCCs of a significant administrative burden and enable them to place attention on the delivery of in-garrison patient care;

c. the DPP cannot produce doctors, specialty nurses or pharmacists. Accordingly, in areas of the country where it has historically been difficult to secure these services the cost of attracting medical professionals to meet CF needs will be significant; and

d. in order to achieve the 1 Apr 2000 implementation date for the 1-800 call centre and on-site provider arrangements, CFMG HQ will need strong and timely support from DND and PWGSC procurement staffs.

DND/VAC Centre for the Support of Injured and Retired Members and Their Families

2.267 Continuity of care in its most traditional sense, has been and continues to be an issue of concern for the CF. So too is the broader issue of continuity of care while the member is in the CF, after release and while he or she is in retirement.

2.268 In the past, the CF has tended to complete the pre-release medical and then let the member make his or her own administrative arrangements to obtain a provincial health card, deal directly with VAC re pension arrangements, obtain prosthetics, wheel chairs etc. This process did not work well as members who were the most ill or most seriously injured were often in greatest need of a range of services, but were least able to seek them out due to their medical conditions. In many instances the patient felt abandoned by the system and the CF. The service member has often become frustrated that an organization to whom they had given so much, no longer had an interest in them when universality of service demands could no longer be met.

2.269 The CF Quality of Life Initiative determined that "...there is a requirement for a central organization to provide information, referral and assistance support for pension entitlements and other concerns of all CF members, retired/released members and their families or survivors..."[42]. Accordingly, on 13 Apr 99, the DND/VAC Centre for Support of Injured and Retired Members and Their Families was opened as an ADM(HR-Mil) organization.

2.270 The review team has been advised that the new centre is frequently being accessed by members for assistance. With a VAC member at the DG level working in the DND office and a CF member (B Gen) working in VAC, Quality of Life Project Office personnel indicate that significant benefits from this arrangement are already being seen. While legislative changes passed in 1995 have enabled VAC to reduce its time for processing first time pension applications from eighteen months down to six months, the new working relationship between VAC and DND is expected to shorten that time even further.

Conclusions Related to DND/VAC Centre for the Support of Injured and Retired Members and Their Families

2.271 The review team has concluded that:

a. the DND/VAC centre is an appropriate mechanism for addressing the issue of continuity of care in the strategic sense as articulated by CDS;

[42] ADM(HR-Mil) CANFORGEN, DND/VAC Centre for the Support of Injured or Retired Members, 13 Mar 99

b. there appears to be commitment and support for this effort on the parts of both the CF and VAC; and

c. this arrangement has begun to show some tangible results.

CF98 - Report on Injuries and Immediate Death

2.272 The CF 98 is a significant entry on the medical file of a service member, as it is the critical document required for pension claim purposes. The CF 98 is the form which records the occurrence of an injury or onset of an illness brought about by military duties. Two significant problems associated with the administration of this form which create problems for the service member are:

a. the CF 98 is completed, but is not placed on the members medical file, is misfiled, or lost; or

b. a CF 98 was not completed in the first instance.

2.273 As discussed in the earlier section, **Administration and Management of Patient Records,** filing of medical records in general appears to be problematic in the CFMS and some CF 98s get caught up in those circumstances. The reasons that some CF 98s were not completed in the past vary. The following is a partial list of some of the reasons cited for the review team why CF 98s have not been completed:

a. the injury was not considered sufficiently significant to warrant completion of the form;

b. the medical doctor who treated the member was unaware of the requirement for the form; or

c. the onset of the serious illness was gradual, and hence the form was not considered the way it routinely would have been in a traumatic incident or event.

2.274 As a result of the number of incidents cited during recent investigations into the medical service and care for injured personnel, the QOL project team undertook a recent initiative to overhaul the CF 98. The revised CF 98, which is expected to be in use by 1 Jan 2000, will no longer require the input of medical information by the CFMS. The intent of implementing the revised procedures is that completion of the CF 98 will become the joint responsibility of the commander officer and the member. Upon completion the form will be forwarded directly from the unit to the DND/VAC centre in order that the record is there for future requirements. It is anticipated that this shift of responsibility will increase the likelihood that the form is completed, and providing it immediately to the DND/VAC centre records the event with the entry point to the pension authorities and enables them to begin building a history on the affected member.

2.275 The medical information resulting from any clinical assessments of the patient should be accessible in the future as it will be archived on the patient file. While accessing the medical file may not be necessary with the CF 98 readily available, VAC authorities will be aware that they can access the information if needed.

Conclusion Related to CF98 - Report on Injuries and Immediate Death

2.276 The review team has concluded that:

a. the CF98 has been administratively troublesome to the CF and its patients in the past, to the extent that at times the completed forms are not available when patients must apply for medical pension benefits; and

b. the Quality of Life initiative has recognized the importance of the CF 98 to the member and has developed a revised process with new forms which are scheduled for introduction 1 Jan 2000.

Canadian Forces Member Assistance Program (CFMAP)

2.277 On 22 Apr 99, ADM(HR-Mil) announced the Armed Forces Council approval of CFMAP which, while protecting the affected individual's confidentiality, is intended to provide psychological and emotional support to CF members and their dependents. The program is particularly geared to assisting members who have been victims of harassment, sexual harassment or sexual assault.

2.278 The CFMAP is available to Regular Force members as well as Primary Reservists, Cadets, Cadet Instructors Cadre, Canadian Rangers and their families. While the program targets to assist personnel on a relatively short term basis, with professional counseling to be available up to a maximum of eight sessions, the rationale is that this amount of assistance should enable the professional counselor to determine if further medical intervention is required.

2.279 The service is readily available by calling a 1-800 number in Canada or the US or placing a collect call from overseas. This service is available 24 hours per day, 7 days per week.

Conclusions Related to Canadian Forces Member Assistance Program (CFMAP)

2.280 The review team has concluded that:

a. the CFMAP offers the potential to fill a significant gap in patient care currently being delivered to CF members with consideration given to confidentiality of patient information and career implications which had, in the past, been a significant concern to CF members. The non-threatening way that this program has been set up should go a long way to encourage personnel who might otherwise have shied away from seeking treatment, to step forward and take advantage of this service; and

b. the development and standing up of the CFMAP visibly demonstrates that the CF is ready and willing to invest in new and innovative programs designed to address medically related quality of life issues for the CF member and other closely associated personnel.

Operational Behavioural Sciences Centres

2.281 In the fall of 1998 Program Management Board approved the establishment of Operational Behavioural Sciences Centres at 5 sites across Canada: Halifax, Valcartier, Ottawa, Edmonton and Victoria. These sites were scheduled to open in September 1999 with the primary aim of supporting individuals who were suffering from an illness or normal reactions to abnormal situations that have been encountered in operations. These illnesses or reactions often become evident through substance abuse, addiction, depression, anxiety or a range of psychiatric disorders such as post-traumatic stress disorder (PTSD).

2.282 The primary resources that will be drawn upon to provide the anticipated services are: social workers, mental health nurses, psychiatrists, clinical psychologists, doctors, chaplains, and community health nurses. The concept is that the core services will be provided by the 5 personnel assigned to each centre – one of each of a psychiatrist, psychologist, social worker, a mental health nurse and a chaplain. Other expertise will be drawn upon as required.

2.283 These illnesses or reactions that are impacting on significant numbers of CF personnel have come to light through the McLellan report on Care of Injured and Retired Personnel and their Families and the SCONDVA report. As one of the Quality of Life initiatives that has resulted from those two reports the requirement for a capability such as the Operational Behavioural Sciences Centres was determined to exist. Not unlike the CFMAP, confidentiality is a cornerstone of this program and members are strongly encouraged, by the CF, to make use of the facilities to address their problems.

Conclusions Related to Operational Behavioural Sciences Centres

2.284 The review team has concluded:

a. the standing up of a program such as this, with the commitment of associated funding, indicates the DND/CF resolve to address the psycho-social challenges facing CF members as a result of their work in theatres of operations; and

b. the CF needs to recognize that for programs such as the Operational Behavioural Sciences Centres the definition for *theatres of operations* cannot be restricted to only those activities taking place on international soil.

Information Guide for CF Health Services

2.285 The Surgeon General is in the final stages of drafting an information guide for CF members and other eligible persons entitled 'Understanding and Accessing Your Health Care Benefits'. The guide is intended to outline the health care benefits and services that are publicly funded, available to members and other eligible persons and provide guidance on accessing the care.

2.286 The issuance of this information brochure coincides with the standing up of aspects of the DPP. There are several elements of this brochure that should be very appealing to recipients of CF medical services and address areas that members have expressed to the review team as being of concern to them in obtaining medical care.

2.287 One item that is highlighted in the brochure is the Spectrum of Care (SOC) document. This is a relatively new document resulting from Op Phoenix. As with any new initiative, communication is always a challenge. Not all CF members are aware of their eligibility for some of the publicly funded benefits to which they are entitled.

2.288 A second new initiative to be introduced by the CFMS is the CF Health Information Line (CF HIL). This toll-free number will be accessible 24 hours per day, seven days per week and displayed on the front of the members' CF Health Identification Card. If members use the hot line as a matter of course:

a. the access to health care advice and general health information should, at times, save the member from actually making a trip to a health care facility and enable him or her to obtain general health information anytime; and

b. the guidance on where and how to access health care services aspect of the CF HIL should prevent instances where the member arrives at a CF health care facility only to find that it is closed or cannot provide the required service. This service should not only be viewed by the member as a convenience, but should also reduce patient risk as valuable time will not be wasted seeking out services at sites where they are unavailable.

Conclusion Related to Information Guide for CF Health Services

2.289 The review team has concluded that:

a. the development of the health information guide is a greatly needed new initiative which offers significant benefits to CF members seeking health care services; and

b. the brochure will be particularly helpful to members if the CF, in turn, delivers on what it tells members in the document. In order to do this:

(1) the hotline will need to be staffed by knowledgeable, polite, courteous personnel who are looking out for the patients' best interests medically, and are perceived by the patient to be doing so; and

(2) there will be a need for mechanisms to ensure that 'hot line' personnel have the most up to date information relating to CF clinic hours, extent of services that are available at the respective facilities, listings of designated providers that are most conveniently available to the member and other information that would be relevant to assuring that the member receives a high level of customer service, and

c. the brochure will be particularly helpful to the member if it is updated periodically and develops a reputation of being a reliable source of information to assist the member in receiving good health care.

General Conclusions Related to New Initiatives

2.290 The review team has concluded that:

a. the CF and the CFMS have recognized that there have been systemic deficiencies in DND/CF related to provision of in-garrison care and quality of life for members. By embarking on these new initiatives CF members should realize that their feedback has been heard and is being taken seriously;

b. putting these new initiatives in place is not an isolated CFMS effort, but rather calls for cooperation support and assistance from other areas of DND/CF and other government departments. One area where the CFMS was in particular need of support at the time of writing this report is from ADM (Mat) and PW/GSC procurement/contracting staffs to assist in progressing the DPP;

c. these new initiatives provide a start point down a long road to regaining the trust and confidence of CF members in the senior leadership's commitment to providing appropriate in-garrison medical care and taking significant steps to improve the service member's quality of life. Announcements and delivery of new initiatives will not be sufficient on their own. CF members not only expect nigh quality in garrison medical care they need to perceive that they are receiving it. Continuity of care, appropriate medical treatment and associated administration while on TMCs, proper management of their patient records, courteous professional treatment by staff providing direct and ancillary services related to in-garrison care all need an appropriate level of attention to assure required levels of patient trust and confidence; and

d. the CFMS and its associated CF and VAC partners deserve credit for pursuing initiatives that have proven to be successful in the civilian sector and recognizing their applicability for the military (e.g., the 1-800 call centre concept for triage and other patient assistance has been extremely popular and well-received in the province of New Brunswick and is now being looked at seriously for Ontario).

BENCHMARKING THE CANADIAN FORCES MEDICAL SYSTEM

2.291 Benchmarking, by definition, is "a systematic and continuous process of measuring and comparing an organization's business processes against leaders anywhere in the world to gain information which will help drive continuous improvement."[43] In order to conduct this review of the CFMS in accordance with the established study objectives, it has been useful to compare the provision of in-garrison health care provided by the CFMS to the manner in which similar services are offered by other military organizations. While an extensive and detailed investigation and comparison was not conducted with a large sample of countries, a generic comparison with three military organizations was undertaken to determine what have been the imperatives for change to military medical services and the organizational, structural and procedural responses to those imperatives. In addition to the discussion in this section of the report, benchmarking findings have been included as they applied to specific topics throughout the report.

[43] Sharp, C.A. (1994) Industry Best Practice Benchmarking in the Evaluation Context. Evaluation News and Comment.

2.292 Imperatives for Change. Since the end of the Cold War, all western nations have dealt with new challenges to their military organizations and missions. Reductions to operational and support forces have been accompanied by infrastructure reductions and fiscal restraint. Medical services within these organizations have not been immune to these factors, which in turn have necessitated changes to the way health care services are provided to military members. General downsizing of military forces has resulted in parallel decreases in medical facilities. The US DoD has reduced its military hospital facilities by 35 per cent between 1987 and 1997, while the UK Defence Medical Service has closed all military hospitals except two in Gibraltar and Northern Ireland. The NZDF provides one integrated medical service that includes operational and non-operational medical support with no military hospital infrastructure of its own. The medical service provided by the NZDF is essentially an occupational health service to ensure that service personnel are fit for their military roles. It offers a primary health care service in-garrison, with referral and patient management into the New Zealand public/private health service for secondary health care and above.

2.293 An additional imperative for change has been the rising cost of medical care - both in the civilian and military communities. Some of the major causes are the availability and use of improved technology including new diagnostic procedures, new and expensive equipment and treatment regimes. There is also increased utilization of the health care system in general as individuals are taking more responsibility for their health and are seeking health care at a greater rate than ever before. In addition, changing demographics impact health care as the relative age distribution within the population changes.

2.294 All military organizations included in this benchmarking review acknowledged that, while providing health care during peacetime is an important mission, the first priority of the military medical service is to support military operations. In light of the imperatives for change, military organizations found that a new approach was needed to meet peacetime demands for health care while preserving the capability to deploy uniformed medical personnel to support operational missions.

2.295 All organizations benchmarked with the CFMS have adopted an approach which increasingly relies on the civilian medical system for its non-operational requirements. In the UK, restructuring of medical services in-garrison has shifted to civilian hospitals. Through an agreement with Britain's National Health Service, the MoD has created Ministry of Defence Health Units (MDHUs) in 12 civilian hospitals, staffed by military medical personnel.

2.296 In responding to the challenge of maintaining medical combat readiness while providing optimal health care for all eligible members, the US DoD has introduced TRICARE. TRICARE is a regionally managed health care program for all eligible members which brings together the health care resources of the Army, Navy and Air Force and supplements them with networks of civilian health care professionals to provide better access to services while maintaining the capability to support military operations. Primary Care Managers are assigned to each member as the single point-of-contact for non-emergency health care. Depending on the locale and availability of medical professionals, members may select a Primary Care Manager at a military

hospital or clinic, or a civilian professional who is a member of the contracted network in the community. Primary Care Managers provide and coordinate care, maintain health records and recommend preventative and wellness services and arrange for specialists or hospital admissions when necessary. In most cases, selection of the Primary Care Manager rests with the member.

2.297 The NZDF provides one integrated medical service that includes operational and non-operational medical support. Organizationally, there is an operational health service which is in uniform and able to deploy overseas, while the non-operational service is both uniformed and civilian. The operational health service (uniformed personnel) focuses on operational training and exercises while the non-operational service provides the day-to-day in-garrison health services and patient management into the public/private health sector. Military personnel are integrated into the non-operational system to ensure staff rotations and clinical training. The NZDF views the health care of personnel in-garrison as directly relating to maintaining them fit for service, and therefore is part of the continuum of operational care. Resources, including capital costs, personnel and operating costs are disproportionately allocated to non-operational health care, but the priority of effort given to personnel, training etc. is assigned to operationally deployable medical resources.

2.298 The following overall assessments of military health care services were provided to the review team by the countries benchmarked with the CFMS. A comparative analysis is summarized in a table at Annex B to this report.

a. UK Defence Medical Services. The basis for peacetime medical establishments is the operational requirement for medical support. The establishment is based on the number of medical personnel required for deployed operational medical units, allowing for a small addition for essential tasks that need to be undertaken by uniformed personnel when the operational medical services have deployed. There is also a margin for training and manning to take account of personnel on specialist training, post graduate work etc. In-garrison care is the responsibility of the individual Armed Service and is provided by a mixture of medical personnel required for operational purposes supplemented by civilian doctors directly employed by MoD and by civilian general practitioners under contract. The standard of primary care within the UK Defence Medical Service is characterized as "currently fragmented and uneven in its quantity and quality".[44] As a consequence, the MoD plans to centralize the management of its primary care under the Surgeon General, with devolution of some responsibilities to individual Medical Directors General. The purpose of centralization is to facilitate implementation of statutory medical regulations, accreditation and clinical governance.

[44] Brigadier L.P. Lillywhite, Director of Medical Personnel, Training and Policy, Surgeon General's Department, Ministry of Defence.

Secondary medical care is also considered "currently unsatisfactory" and is under review.[45] The Surgeon General is responsible for the employment of most of the hospital specialists in peacetime and for assigning them to individual Services for employment in operational units when required. In peacetime, these specialists are employed in MoD Hospital Units which are integral to the National Health System (NHS). The capability that has been lost as a result of closure of the major service hospitals is to be replaced by a Centre for Defence Medicine to be allied with a civilian centre of medical excellence. As a result, secondary care relies heavily on the civilian NHS within which uniformed secondary care personnel work.

A major problem identified by the MoD is that the National Health Service cannot give priority to servicemen except for clinical reasons. This poses problems getting servicemen back to duty who are suffering only minor conditions, leading to unacceptably long waiting lists. Similar to the Canadian situation, this was particularly noticeable for orthopaedic cases.

Recruitment and retention of medical staff is a particular concern to the MoD. They report that there has been a 'considerable and unsustainable outflow' of staff, particularly from clinical areas. This has been attributed to the rapid implementation of change initiatives and that the clinicians and technicians "seem to be suffering the disadvantages of both the military and the NHS and the advantages of neither".[46] A third factor has been attributed to the disparity of salaries between specialists within the Armed Forces compared with potential earnings in the civilian sector. Closer integration into the NHS has made the relative differences more obvious;

b. New Zealand Defence Force. A detailed benchmarking of the NZDF Health Service is provided at Annex B using criteria and issue areas reflected in the review objectives. However, the following qualitative assessment was provided to the review team of the level of satisfaction of military members with their military medical service. Anecdotal evidence indicated a general acceptance by military members of the standard of the NZDF medical services. Organizationally, the provision of medical care is seen as a priority as it is directly reflected in Force morale. However, it was reported that "some areas (NZDF members) may have unrealistic expectations of full medical care without realization of the prioritizing of resources and medical decisions based on health needs not wants." It was emphasized by the NZDF that their mandate is not to provide 'full medical care', but 'comprehensive medical care'; and

[45] Ibid.
[46] Ibid.

c. U.S. Department of Defense Health Care: The U.S. DoD health care system has undergone significant changes responding to imperatives similar to the CFMS. Faced with rising costs, access concerns to needed services and the requirement to maintain a trained and ready medical corps to support members in-garrison and on deployment, the Military Health Services System has adopted the TRICARE program to address its in-garrison medical needs. The TRICARE system relies heavily on close integration with the civilian health care sector and was introduced specifically to address the following concerns:

- Improve overall access to health care for entitled members
- Provide faster, more convenient access to civilian health care
- Create more efficient ways to receive health care
- Offer enhanced services, including preventative care
- Introduce choices for health care and
- Control escalating costs

Despite the goals and intentions of the TRICARE system, several shortfalls in this delivery mechanism have been identified by the U.S. General Accounting Office and the Congressional Defense Committee. Specifically, concerns have been raised that the managed care program compromises the quality and availability of health care and does not provide uniform benefits and service to all members. The program has had difficulty attracting well-qualified civilian physicians and providing access to quality, low-cost care in remote or rural locations. Civilian medical providers have expressed concerns about administrative shortcomings of the TRICARE system which contribute to their reluctance to participate in the program. The Congressional Committee was particularly concerned that administrative processes may take precedence over the provision of needed health care services. Although a cornerstone of the TRICARE program is the establishment of specific standards for timely access to medical care, these standards could not be enforced without an adequate system to monitor adherence to those standards.

The DoD is also taking very active steps to implement a combat stress control program to improve the military's ability to control combat stress among its service members. It is recognized that increased military deployments, especially to areas of conflict, have generated increased levels of stress among service personnel. The DoD is now emphasizing the critical importance of leadership and education, making military leaders more aware of the effects of combat stress on individuals and the military unit. To this end, DoD has begun planning for enhanced training of its leadership to help them recognize the signs of combat stress and to help them provide assistance to the service member.

Responses to a 1997 DoD health care survey rated satisfaction levels of its beneficiaries to the services received through their military medical health care system. The following table summarizes the results of the DoD satisfaction survey and responses to similar topics received from the CF patient focus groups held by the CRS review team. While sample populations, methodologies and timeframes differ (1997 vs. 1999), it is interesting to note the relative ratings of the respective military health care systems.

Table 6

Military Health Care Satisfaction Ratings		
	1997 DoD Health Care Survey	1999 CF Patient Focus Group Survey
Personal Satisfaction with Military Health Care System	57.1%	44 %
Overall Rating of Military Health Care System as "good to excellent"	70.9%	70 %

Conclusions Related to Benchmarking the Canadian Forces Medical System

2.299 The review team has concluded that:

a. there is a widespread reliance on the civilian health care sector by other military organizations to provide in-garrison medical care in order to preserve a capability to deploy uniformed medical personnel to support operational missions;

b. military medical establishments are primarily based on identified operational requirements, resulting in a need to supplement in-garrison care with civilian resources;

c. timely access to medical care is a major concern of the service member and remains a goal of the military health service;

d. socio/psychological issues, and strategies to deal with them, are a significant concern of military health services;

e. attrition of physicians is high (40 per cent to 80 per cent) after completion of obligatory service in all organizations benchmarked with the CFMS; and

f. all organizations included in the benchmarking review indicated their military medical organizations were involved in developing strategies and new initiatives in order to provide appropriate health care services to military members while preserving the capability to meet operational medical commitments.

PART 3 - CONCLUSIONS AND RECOMMENDATIONS ON EACH MANAGEMENT ISSUE

Conclusions Related to Strategic Direction

3.1 The review team has concluded that:

a. providers of health care services within the CFMS do not feel there is a clearly articulated strategic direction for the provision of medical services in the CF;

b. lack of strategic direction has left a change-fatigued CFMS wondering what the long term plan for the organization is and what are its strategic priorities for getting there;

c. development of strategic direction requires a thoughtful, interactive, iterative process that fully engages those who are clients, stakeholders and deliverers of the program; and

d. CFMS staff need to know that that this process is in train, that they will have an opportunity to contribute to the plan and that there will be comprehensive communications on the outcome of strategic direction for the Branch.

Recommendations Related to Strategic Direction

3.2 The review team recommends that:

a. steps be taken without delay to put in place a process to develop strategic direction for the CFMS Branch;

b. a communication strategy be developed to inform all members of the CFMS of the objectives and process related to formulation of 'Strategic Direction'; and

c. the casting of strategic direction be an exercise that is inclusive of all aspects of Health Services and not restricted to medical services.

Conclusions Related to the Impact of Op Phoenix on In-garrison Care

3.3 The review team has concluded that:

a. implementation of Op Phoenix has had both positive and negative impacts;

b. from a positive perspective, putting in place aspects of Op Phoenix, such as accessing services from the civilian sector, has educated the CFMS on challenges that may not have been fully appreciated at the planning phases of the reengineering effort; and

c. on a more negative note, there has been a partial and fragmented approach to implementation of the Op Phoenix concepts. The process, which has been extended over a prolonged period of time, and is not yet complete, has been very difficult for medical service providers and their clients to the point that issues of morale and trust are surfacing in significant ways. The result has been an erosive effect in these areas from which the review team believes it will take the CFMS considerable time to recover.

Conclusions Related to the Standard of Health Care Provided to CF Members

3.4 The review team has concluded that:

a. the CFMS, through its enabling documentation (QR&Os) and Spectrum of Care publication, has the authority to provide health care services which, at a minimum, are comparable to those offered under provincial health care plans;

b. in areas relevant to the occupational aspects of the CF, the comprehensiveness of medical coverage actually exceeds that provided to "insured Canadians";

c. focus group and interviewee responses acknowledge this coverage, but indicate that the CFMS falls short in the delivery of this capability due to administrative burdens, the perceived decline in service levels due to delays imposed by interfacing with provincial health systems, and customer service levels offered by the CFMS; and

d. from a medical skills, health treatment and spectrum of care perspective, the CFMS is comparable to provincial health care services available to all Canadians. However, the manner in which these services are delivered to the CF member appears to fall short of the civilian health care sector. As determined by the Review Team through interviews and focus groups, CF medical personnel have collectively admitted to a low level of morale coupled with a lack of professional challenge, which has contributed to an approach to their work reflected in patient care and the patients' perception of the care they are receiving.

Recommendations Related to the Standard of Health Care Provided to CF Members

3.5 The review team recommends that:

a. CFMS professional medical staff be given clear direction on the level of care that they are expected to provide in-garrison. This would include a statement on the scope and range of services that are to be provided;

b. process re-engineering be conducted at the Health Care Centre/Base Clinic-level to evaluate current administrative procedures and, where they are lacking, make necessary adjustments to improve customer service at all in-garrison clinical settings;

c. an option for trans-regional accessibility to civilian health care treatment be made available to CF patients in order to align operational and medical priorities with optimal availability of care to reduce access delays. Judgements on making trans-regional treatment available to members should be made on a case by case basis;

d. appoint an external organization to conduct independent audits of CF health care facilities (in addition to the Staff Assistance Visits (SAVs) conducted by CFMG/DGHS staff) to measure and benchmark delivery standards; and

e. consideration be given to seeking provincial certification/accreditation of CF health care facilities from the Canadian Council on Health Service Accreditation to assure CF patients of comparable care to that which is available through provincial/civilian sector facilities.

Conclusions Related to Continuity of Care

3.6 The review team has concluded that:

a. continuity of care is a fundamental concept in the practice of family medicine and is not perceived as being delivered to the extent that it could or should be in the CF;

b. allied military and paramilitary organizations are implementing similar strategies to those being pursued by the CFMS by striving to improve continuity of care for their personnel through greater use of civilian medical resources. There are other strategies that some of the allies are implementing in addition to civilianization that may warrant consideration by Canada. It would be worthwhile for the CFMS to be aware both of initiatives that worked for other defence forces and those that didn't, in order to derive maximum benefit from these other experiences;

c. achieving continuity of care is generally considered by the medical profession to be more important in the treatment of chronic cases than in the treatment of ailments of a more routine nature; and

d. the extent to which continuity of care is not achieved in the military impacts patient morale and, at times, threatens the quality of care being received.

Recommendations Related to Continuity of Care

3.7 It is recommended that:

a. initiatives to facilitate the hiring of civilian physicians for temporary and indeterminate assignments, such as the Designated Provider Plan and other strategies, be pursued as a matter of priority;

b. strategies that other nations have pursued (e.g., primary care manager in the US military) be examined for their applicability either site-by-site or on a more national basis in the CFMS;

c. Surgeon General highlight for all CFMS staff through the Branch Newsletter, personal site visits, the Defence Information Network web site, and other venues, the importance of achieving continuity of patient care to the extent practical and implementable in the in-garrison setting, with the highest priority being placed on members with chronic ailments;

d. procedures be developed at health care centres which will optimize the opportunity to provide continuity of care to the patient and implement CFMO 27-02 to the maximum extent possible;

e. steps be taken to ensure that continuity of care is featured as a curriculum item in all CF courses that have application to clinical and administrative matters relating to the delivery of in-garrison care; and

f. CFMS personnel and leaders in the operational chain of command be reminded of their leadership responsibilities to support CF members in receiving continuity of medical care.

Conclusions Related to the Administration of Temporary Medical Categories

3.8 The review team has concluded that:

a. the temporary medical category concept is premised on sound rationale;

b. while the TMC process is sound, there are administrative aspects that could be improved upon for the benefit of the member and the CF;

c. patients who are currently on or who have been on TMCs, for the most part do not have a good understanding of the process;

d. members are distrustful of the TMC process from a career implications perspective;

e. members often feel ostracized by their peers and sometimes their superiors when they are assigned a TMC;

f. while members had varying views and opinions on how quickly they wanted decisions taken related to their TMCs, it is generally to the benefit of the member and the CF for these matters to be resolved in a timely way;

g. a combination of significant numbers of members assigned repeated TMCs and a sparing use of the medical patient holding list serves as a major frustration for COs who are trying to do the right thing for the patient, but must also accomplish the operational mission with reduced resources;

h. MOs may be subjected to pressures from members and more senior COs on decisions related to TMCs - these pressures pose significant ethical dilemmas for the MOs;

i. while lack of leadership involvement can be linked to a number of cases where the TMC process has not functioned as expected, COs and supervisors recognize that the process is an administrative one and they have a significant role to play to make sure it functions well;

j. IM/IT offers the potential to assist in the administration of TMCs and somestandalone systems in the field are being developed, used and contributing to the administration of TMCs;

k. there are significant costs attached to having members on TMCs; and

l. to their credit, D Med Pol staff have made considerable progress in recent months to reduce the backlog of TMC files referred to NDHQ to manageable levels.

Recommendations Related to Temporary Medical Categories

3.9 The review team recommends that:

a. efforts be made to improve patient knowledge and awareness levels on temporary medical categories;

(1) all CFMS clinical staff should be knowledgeable on the TMC concept and process and be ready to answer frequently asked questions on TMCs; and

(2) supplies of the brochure recently issued by D Med Pol on TMCs should be made readily available in medical facilities where in-garrison care is provided to CF members and copies should be distributed freely to members.

b. leaders be sufficiently involved in the administration of TMCs so that the member is not administratively put off to the side, without sufficient supervision or support;

c. leaders fulfill their responsibilities to ensure that colleagues of the member on TMC are aware of the process and understand why TMCs are used;

d. as a general rule, decisions related to the administration of TMCs be taken in as timely a way as possible and practical, taking account of the best interests of the patient, the unit and the CF;

e. training venues that introduce MOs to the practice of medicine in the CF and address the concept of TMCs, make provision for educating the MO not only on mechanics of TMCs, but also on some of the related human resource dynamics; and

f. when Surgeon General and other CFMS personnel are briefing various forums of CF leadership, they take the opportunity to highlight leadership responsibilities related to TMCs and continuity of care.

Conclusions Related to Command and Control of Delivery of in-Garrison Care

3.10 The review team has concluded that:

a. lack of clarity of responsibilities, authorities and accountabilities is having an impact on the delivery of the care;

b. delivery of in-garrison health care is very dependent on the successful coordination and integration of the resources of three separate chains of command. This structure is highly influenced by personalities and differing priorities rather than organizational principles;

c. the current command and control structures within the CFMS hinder the DGHS/CO CFMG from providing corporate, strategic direction or leadership to the bulk of medical resources which belong to the environmental commands;

d. lack of unity of command by the HCC over resources providing in-garrison care impact the ability of the HCC to effectively administer the base health care facility and provide patient focused service; and

e. the existing mandate of the CFMS as provided for by the Op Phoenix concept is best served by the current structure, at this time.

Recommendations Related to Command and Control of Delivery of in-Garrison Care

3.11 It is recommended that:

a. the commitment of CFMG and Command resources in support of in-garrison patient care be stabilized. Service-level agreements between CFMG detachments, Command units and the CF medical facilities should be established to ensure minimum resource commitments in support of in-garrison care;

b. improvements to the delivery of in-garrison care be achieved in the immediate timeframe through administrative, procedural and staffing adjustments rather than structural realignment of the function;

c. the responsibilities, authorities and accountabilities for the provision of in-garrison patient care be clarified between CFMG staff, Command staff, Base Commanders and Health Care providers;

d. HCC responsibilities focus solely on the provision of in-garrison care for CF members and the operation of the CF medical facility. Operational and other CF related medical issues that were formerly addressed by the Base Surgeon pre-OP Phoenix should be addressed by Command medical staffs; and

e. consideration be given in 18 to 24 months to establishing a centralized health services organization.

Conclusions Related to CFMS Resources, Establishment and Staffing

3.12 The review team has concluded that:

a. the provision of in-garrison health care services remains highly dependent on the availability of CFMS uniformed personnel. Arrangements with the public health care sector have not yet matured to meet the objectives envisioned by Op Phoenix;

b. workload and case load statistics and data are not being gathered to permit analysis to determine minimum staffing requirements for both uniformed and civilian health care providers;

c. a decrease in the number of physicians relative to the Canadian population has severely impacted the availability of and access to the public sector health care sector by the CF;

d. the ratio of the number of general practitioners and medical specialists (established positions) to the CF patient population, generally exceeds the ratios of similar occupations in the civilian sector;

e. attention to management and utilization of medical specialist resources, including staffing currently unfilled positions will yield greater benefits to the provision of in-garrison services than increasing the number of established positions;

f. the distribution of a CF population over a wide geographical area (coast to coast), may negate the benefit of having more favourable ratios of medical professionals to patient population than exist in the civilian sector;

g. the CFMS' capability to provide health care services is augmented by accessing services in the civilian sector, thereby increasing the leverage of a dedicated CF medical service;

h. shortfalls of personnel in the CFMS do not equate to insufficient established positions;

i. current shortfalls in the medical assistant occupational category will have a future impact on those medical specialist trades which draw on the medical assistant occupational category;

j. health care coordinators are lacking managerial and administrative training specifically to manage the CF medical facility function;

k. at a time when significant shortfalls are forecast in the availability of GDMOs to provide in-garrison care, greater involvement of the health care administrator in the role of managing activities in the CF medical facility function would optimize the availability of GDMOs for clinical duties; and

l. there is insufficient consideration of command leadership experience in the selection of candidates to fill senior management positions in the CFMS.

Recommendations Related to CFMS Resources, Establishment and Staffing

3.13 It is recommended that:

a. workload, caseload and other performance measurement data be gathered at all CF sites providing in-garrison medical care;

b. existing established CFMS positions be staffed before additional positions are authorized for the respective MOCs;

c. strategies be developed to address current shortfalls in the medical assistant occupation;

d. a two-pronged strategy be pursued to address managerial deficiencies in the CF medical facilities;

(1) HCCs be given appropriate management training before assuming the position and on-going training while they are in the post; and

(2) HCAs and HSOs located in the health care centres assume more of the administrative responsibilities related to delivery of in-garrison care, thereby freeing up clinical practice time of the health care coordinator.

e. position analysis statements of senior positions in the CFMS be examined by appropriate staffs to determine the skill sets required to perform the duties of the respective positions.

Conclusions Related to Recruitment and Retention of Medical Officers

3.14 The review team has concluded that:

a. as the attrition rate for MOs is significantly higher than historical averages, at the same time as little interest is being expressed in traditional entry venues (Medical Officer Training Program), the CFMS will be facing significant military physician shortages over the next several years;

b. the CFMS has a strategy for attracting direct entry officers and is implementing it; and

c. there is no specific strategy being pursued to retain CF medical officers, yet MOs have a range of concerns that could be addressed to make being an MO more attractive.

Recommendations Related to Recruitment and Retention of Medical Officers

3.15 The review team recommends that:

a. the effectiveness of the bonus that has been put in place to attract DEOs be assessed periodically. If it is determined not to be meeting the objective then it should be reassessed and alternate strategies developed;

b. strategies be pursued to ensure an equitable sharing of deployment assignments among GDMOs and specialist MOs;

c. the CFMS represent or otherwise support CF MOs in discussions with various provincial and territorial medical licensing bodies on an as required basis on matters unique to serving CF medical officers (licensing issues, maintaining billing numbers etc.);

d. with the assistance of expert consultant support, the CFMS undertake a study to determine appropriate ways of encouraging clinicians to make a career of practicing clinical medicine with the CF;

e. a validation of the training being provided to MOs be completed to ensure that:

(1) MOs are receiving sufficient and appropriate maintenance of competence and CME to meet their operational and in-garrison responsibilities; and

(2) complete training records are maintained and available to leaders who will be taking decisions on the deployment of MOs (trauma, burns, geriatrics, pediatrics etc.) and

f. the CFMS leadership examine ways to increase the profile of the contribution of MOs in the CF.

Conclusions Related to Morale, Attitude and Capacity for Change in the CFMS

3.16 The review team has concluded that:

a. low morale exists in the CFMS on a widespread basis, and is negatively impacting the attitudes of health care personnel in the clinical setting;

b. reasons for low morale are varied and include but are not restricted to:

(1) change fatigue being felt at all levels of the CFMS;

(2) lack of understanding where the organization is headed strategically;

(3) CFMS personnel sensing a lack of appreciation or understanding from the CF of the demands that have been placed on them;

(4) a perception that the corporate focus on health care has shifted from patient care to the task of implementing OP Phoenix;

(5) leadership concerns within the CFMS;

(6) heavy workload, including in-garrison and operational responsibilities, to which there appears to be no end in sight; and

c. some CFMS personnel have expressed the view that they no longer have the reserves to continue to do their jobs and to cope with further change initiatives. While there are significant initiatives yet to be implemented to strengthen the provision of in-garrison care, the success of these initiatives will be dependent on the capacity of the CFMS health care professionals who must implement the changes necessary for the long term benefit of the CF.

Recommendations Related to Morale, Attitude and Capacity for Change in the CFMS

3.17 It is recommended that:

a. an assessment be made of the amount of assistance that will be required to enable implementation of the recommendations of the CRS review; and

b. the Department support the requirement, once validated, with appropriate financial and human resources.

Conclusions Related to the Administration of In-garrison Patient Care

3.18 The review team has concluded that:

a. patients take a holistic view of their medical care which includes the administration associated with it;

b. CF patients who experience poor administrative practices when receiving in-garrison medical care frequently interpret those problems as poor medical care being provided to the member;

c. not all health care centres have reasonable records management tools in place (Bradma Plates or equivalent) to reduce administrative workload and minimize opportunities for error;

d. lack of internal policy and procedural guidance on the handling of patient files has left CF in-garrison units with very wide latitude in this important process;

e. given the sensitive and very personal nature of medical information it is necessary that protocols be in place for the handling of patient files within the CFMS;

f. the high turnover of medical personnel flowing through the CF medical facilities, particularly Med As who are responsible for the administration and management of the files, has the potential to negatively impact on how files are managed;

g. placing greater responsibilities on the student for learning patient record management through self-study rather being trained under the guidance of an instructor has increased the risk that the Med A may not cover all of the material or, if they do, may not understand it all. While this may be an economical way to deliver the training, it may be less effective and this would never be known without an appropriate validation process;

h. patients' administrative needs are not consistently being provided for when visiting CF in-garrison facilities leaving members with a poor impression of the CFMS and consequently eroding their confidence and trust in the system serving them;

i. medical situations are arising that are not being readily provided for by either the CFMS or the civilian medical system;

j. while these issues may arise due to local circumstances that exist at a particular time similar problems are surfacing in multiple locations; and

k. while workable (not always ideal) solutions are generally found, the more that HCCs know about how others have handled similar situations, the better placed they should be to respond appropriately when required.

Recommendations Related to the Administration of In-garrison Patient Care

3.19 It is recommended that:

a. CF health care centres examine their internal administrative functions and processes to ensure that:

(1) such basic information management tools as Bradma Plates or equivalents are in place; and

(2) other mechanisms for streamlined processing of in-garrison patients are in place and functioning as intended;

b. the CF policy and procedural guidance on handling of patient records be made sufficiently clear and complete as to provide an appropriate level of protection for the documents, provide a reasonable degree of assurance of the integrity of the information contained there in and provide assurance to the member that their medical information is being adequately safeguarded while in the custody of the CFMS and civilian medical service providers;

c. standard operating procedures be put in place and kept up to date at all CF medical facility sites to assure consistent high quality administration supports the delivery of in-garrison medical care;

d. HCCs track medical incidents that have arisen that cannot be accommodated through CF in-garrison patient care arrangements or the civilian system. These incidents should be advised to Surgeon General for his/her information; and

e. sharing of how these experiences were handled should take place at forums where HCCs are brought together with migration of ideas being one of the objectives of the session.

Conclusions Related to Mechanisms for Obtaining Civilian Physician Services In-garrison

3.20 The review team has concluded that:

a. the decision to realign the CFMS organization structures to support a more operational focus without having systems in place to backfill MO positions with contract civilian physicians has placed an enormous burden on HCCs responsible for the delivery of in-garrison patient care;

b. this burden has in turn been passed on to military MOs who have not only had to respond to the demands of an increased tempo of operations, but have also had to make further personal sacrifices to ensure that patient care continues to be delivered in garrison (recalled from leave, leave cancelled, MO on TMC supposed to work half days working 12 to 14 hour shifts etc.); and

c. use of stop-gap measures for contracting civilian doctors has become a matter of routine in most CF medical facilities in most cases is unfair to the contract physician and contravenes accepted public service hiring practices as provided for in the Public Service Staff Relations Act. For many CF medical facilities the DPP is not scheduled for implementation for sometime.

Recommendations Related Mechanisms for Obtaining Civilian Physician Services In-garrison

3.21 It is recommended that:

a. the Surgeon General with the support of the CF, progress implementation of the DPP at CFMS in-garrison medical facilities across Canada as expeditiously as is reasonably achievable; and

b. pending implementation of the DPP, CF sites providing in-garrison care review the appropriateness of continued use of the DND 2058 form when engaging temporary civilian physicians. If a more appropriate mechanism cannot reasonably be put in place before inception of the DPP, then HCCs should, at the very least, advise civilian doctors currently on contract with the CF that the DPP is coming and what the implications of that change could mean for them.

Conclusions Related to Securing Specialist Services for Delivery of In-garrison Care

3.22 The review team has concluded that:

a. as a general practice, it would likely not be appropriate for DND/CF to be seen to be jumping the civilian sector queue by sending CF members to fee for service health care providers; and

b. there are strategies that could be pursued in order to obtain specialist services quickly under extraordinary circumstances. Two sources are through purchasing blocks of physician time and trans-regional treatment.

Recommendations Related to Securing Specialist Services for Delivery of In-garrison Care

3.23 It is recommended that:

a. statistics be gathered and analyzed to determine areas where the CF generates unusually high numbers of cases requiring certain specialty care from the civilian sector. Where regular patterns exist and there is difficulty securing that care then arrangements should be made to purchase block amounts of physician time; and

b. in non-emergency situations, on a case-by-case basis, assessments be made to determine if extraordinary steps should be taken to secure specialist care for the member, outside his or her geographical posting area, on a more timely basis than could be provided locally.

Conclusions Relating to Provision of First Responder Care In-garrison

3.24 The review team has concluded that:

a. while first responder care is a peripheral issue for the medical services branch, the fact that confusion exists among those responsible for provision of in-garrison care makes it an issue that could impact the level of patient care provided the soldier, sailor and air man or woman; and

b. the Surgeon General has a responsibility to provide medical advice to the CDS on the adequacy of the current arrangements for the provision of first responder care. He should be able to tell the CDS if the CF member is receiving first responder care that is equivalent to that being received by the average Canadian and, to the extent that it may fall short, the degree of increased risk for the member.

Recommendations Relating to Provision of First Responder Care In-garrison

3.25 It is recommended that:

a. Surgeon General be prepared to offer medical advice to the chain of Command, including Base Commanders, on matters related to the delivery of first responder care in-garrison;

b. as part of the staff assistance visits to CF in-garrison locations the Director Health Services Delivery include the adequacy of first responder care as an area to examine. Recommendations resulting from such assessments should serve as a point of discussion with the Base Commander, the Health Care Coordinator, Fire Chief and any local authorities that might be impacted. Appropriate actions should result based on the direction of the Base Commander; and

c. communication be issued at the base/wing/formation level explaining the local arrangements for delivery of first responder care.

Conclusions Related to Migration of ideas:

3.26 The review team concluded that:

a. there is little opportunity within the CFMS to readily share innovative ideas and solutions that would contribute to the efficient and effective delivery of in-garrison health care;

b. CFMS personnel are generating good ideas, particularly ones relating to data base management of patient information, and are putting those ideas into place at some sites. Sharing of these IM/IT ideas offers the opportunity for leveraging on ideas that have already been developed; and

c. the sharing of ideas will not occur on its own, but will require a deliberate effort in order to derive maximum benefit from this concept.

Recommendations Related to Migration of Ideas

3.27 It is recommended that:

a. CFMS personnel ensure that, when setting up training programs, workshops, conferences or other forums where branch members will be brought together, that some time is set aside for sessions where sharing of ideas could take place; and

b. the Staff Assistance Visit (SAV) capability that has recently been stood up in the Assistant Chief of Staff Health Services Delivery (ACOS HS Del) be utilized to the fullest extent possible as an impetus and catalyst behind the migration of ideas across the CFMS.

Conclusions Related to Information Management/Information Technology Support to CF Health Services

3.28 The review team has concluded that:

a. the CFMS does not have an adequate IM/IT system to provide real time knowledge of the health status of its operational units to support operational roles;

b. an integrated health information system is needed to support the CFMS due to the high mobility of the CF population, operational requirement for the health status of the CF, increased reliance on the civilian health care sector and the requirement to manage a uniform quality of health care delivery at all CF sites;

c. the CF in-garrison health care delivery models have not been adequately established and refined to facilitate the development of a CFMS IM/IT infrastructure;

d. increased integration between the CFMS in-garrison and the civilian health care sectors raises security issues as the CF has higher security standards for health information than the civilian sector; and

e. the ability of the CFMS to make appropriate management and resource allocation decisions has been constrained by the lack of available health care data, and workload volumes and statistics.

Recommendations Related to Information Management/Information Technology Support to CF Health Services

3.29 It is recommended that:

a. the in-garrison health care delivery model be established and be put in place to determine the necessary IM/IT support that will be required;

b. the CF develop policy related to acquiring, handling and release of health information for CF members both internally and externally;

c. the information requirements to support CF occupational health requirements be determined, along with the methods on how this information will be acquired and controlled;

d. the CFMS update and streamline business and management practices currently in use in order to streamline administrative processes and improve handling of patient information in the clinical setting;

e. CFMS business practices be adapted to take advantage of commercial off-the-shelf health care software applications to reduce design and development costs and facilitate integration with civilian health care providers;

f. plans be progressed to implement IM/IT solutions to support the CFMS that can be quickly put into place with the flexibility to meet changing requirements and conditions in both the CF and civilian health care sectors; and

g. a security risk assessment be conducted with regard to CF health information to facilitate the necessary links to the civilian health care sector.

General Conclusions Related to New Initiatives

3.30 The review team has concluded that:

a. the CF and the CFMS have recognized that their have been systemic deficiencies in DND/CF related to provision of in-garrison care and quality of life for members. By embarking on these new initiatives CF members should realize that their feedback has been heard and is being taken seriously;

b. putting these new initiatives in place is not an isolated CFMS effort, but rather calls for cooperation support and assistance from other areas of DND/CF and other government departments. One area where the CFMS was in particular need of support at the time of writing this report is from ADM (Mat) and PW/GSC procurement/contracting staffs to assist in progressing the DPP;

c. these new initiatives provide a start point down a long road to regaining the trust and confidence of CF members in the senior leadership's commitment to providing appropriate in-garrison medical care and taking significant steps to improve the service member's quality of life. Announcements and delivery of new initiatives will not be sufficient on their own. CF members not only expect high quality in garrison medical care they need to perceive that they are receiving it. Continuity of care, appropriate medical treatment and associated administration while on TMCs, proper management of their patient records, courteous professional treatment by staff providing direct and ancillary services related to in-garrison care all need an appropriate level of attention to assure required levels of patient trust and confidence; and

d. the CFMS and its associated CF and VAC partners deserve credit for pursuing initiatives that have proven to be successful in the civilian sector and recognizing their applicability for the military (e.g., the 1-800 call centre concept for triage and other patient assistance has been extremely popular and well-received in the province of New Brunswick and is now being looked at seriously for Ontario).

Conclusions Related to Benchmarking the Canadian Forces Medical System

3.31 The review team has concluded that:

a. there is a widespread reliance on the civilian health care sector by other military organizations to provide in-garrison medical care in order to preserve a capability to deploy uniformed medical personnel to support operational missions;

b. military medical establishments are primarily based on identified operational requirements, resulting in a need to supplement in-garrison care with civilian resources;

c. timely access to medical care is a major concern of the service member and remains a goal of the military health service;

d. socio/psychological issues, and strategies to deal with them, are a significant concern of military health services;

e. attrition of physicians is high (40 per cent to 80 per cent) after completion of obligatory service in all organizations benchmarked with the CFMS; and

f. all organizations included in the benchmarking review indicated their military medical organizations were involved in developing strategies and new initiatives in order to provide appropriate health care services to military members while preserving the capability to meet operational medical commitments.

PART 4 - ACTION PLAN RESULTING FROM THE CDS TASK FORCE

CDS Task Force - Health Care Support to the Canadian Forces
Putting the 'Care' back into 'Health Care'

EXECUTIVE SUMMARY

4.1 When the CDS was briefed on the draft CRS report on the Review of the Medical Services, he concluded that it could not be released without an accompanying action plan and leadership commitment to make it happen now. To develop the action plan, he assembled a Task Force comprised of military health care professionals and civilian advisors (Enclosure 1). The Task Force went beyond the 59 CRS recommendations and addressed the areas that CRS had identified as requiring further study. The action plan produced contains hundreds of recommendations for action.

BACKGROUND

4.2 The picture painted by CRS is not a pretty one. Yet, it is clear that it is just the tip of the iceberg. The medical system is broken. When the Task Force finished reading the CRS report and completed its first week of in camera briefings, the members were overwhelmed. It did not matter where we looked, something was either badly broken or barely hanging on by a thread. It made us wonder when this was going to start having a serious impact on the Medical Service's ability to provide adequate operational health care support - assuming it did not already.

4.3 Before we move on, lets take a moment to reflect on the Canadian and Military standards of health care. We often hear that the Canadian standard of health care is one of the highest in the world. What is the Canadian standard? Is it the same in Tuktoyaktuk as it is in Toronto? Intuitively, we know that there is a significant difference between the standard available at these two locations. Yet, both are representative of the Canadian standard of care.

4.4 Even when the CFMS was considered 'rich and elitist', the military capability was falling short of the expected or assumed Canadian standard. Why? Because to be able to provide operational health care support where CF members happen to be, we employ some multi-skilled but unlicensed personnel, some of the drugs we administer are unlicensed, and not all of our medical equipment is CSA approved. For the most part, as a training vehicle, we operate in garrison as we do in operations. This is perfectly acceptable under federal statute.

4.5 Whereas before we were able to maintain the gap between the two capabilities at a reasonable level, the closure of CF Hospitals has caused the gap to widen sharply in the last few years. This is not to suggest that we should go back to the ways in which we used to operate.

However, it presents a phenomenal challenge. On the one hand, the civilian trend is expected to be a positive one as new techniques, equipment and drugs are developed and implemented and, as governments reinvest significantly in what many consider to be an underfunded health care system. On the other hand, as unlicensed military personnel cannot work in civilian facilities to maintain clinical competence, the military downward trend is expected to continue and possibly accelerate as skills, knowledge and availability of certain groups of uniformed health care personnel continue to dwindle and deteriorate.

LEGAL BASIS FOR THE CF HEALTH CARE MANDATE

4.6 The CF health care mandate is to provide the health care support necessary to sustain a multi-purpose, deployable, combat capable force across the full spectrum of military scenarios.

4.7 Health is an amorphous field that is distributed to the federal or provincial level of government depending on the purpose and effect of the particular measure at issue. It is for this reason that section 91(7) of the Constitution Act, 1867, serves as the constitutional basis for the CF's health care mandate.

4.8 The 1984 Canada Health Act, the purpose of which is to set out the conditions under which the Federal Government will transfer health care money to the Provinces, explicitly defined CF members out of the definition of 'insured persons'. To have CF personnel included in the definition of 'insured persons' would require Parliament amending the Canada Health Act. The legislation of nine of the ten Provinces provides for the exclusion of anyone having entitlement to health care under federal statute. Furthermore, the legislation of Alberta, Saskatchewan and Prince Edward Island specifically exclude CF members and would also have to be amended accordingly.

4.9 To approach the provinces, the Department would require a bureaucratic and political consensus with Health Canada, PCO, Intergovernmental Affairs, TB, Finance, Corrections Canada, and the Solicitor General (on behalf of the RCMP). The Federal Interdepartmental Health Policy Committee, chaired by Health Canada, is the forum through which the required consensus would have to be reached.

4.10 In short, DND is legally bound to provide for the health care needs of CF members, at home or abroad, in a universal, portable, comprehensible, accessible and publicly administered way. How health care is provided to CF members is left to DND to determine.

RATIONALE FOR A UNIFORMED HEALTH CARE SERVICE

4.11 The physical and mental, health and fitness of CF members are inextricably linked to the readiness, effectiveness, and efficiency of the military as a fighting force. Before sending troops into harm's way, the Chain of Command must know, not only the physical and/or mental health limitations which may preclude successful completion of military tasks, but also the health and fitness levels and employment limitations of CF personnel. In addition, military training and

operations frequently result in serious injuries necessitating immediate access to life-saving health care resources. The military itself is in the best, if not unique, position to provide the necessary timely care.

4.12 This is not to say that uniformed health care providers have to be able to do it all themselves. It is clear that for most of the CF member's career, health care will be provided through a partnership between civilian and uniformed health care providers. However, just as CF members have done, uniformed health care providers have made the informed choice that they would give up their individual rights and freedoms by placing 'Service before Self'. This premeditated decision of unlimited liability to serve, allows uniformed health care providers to serve CF members, anywhere and anytime. They can go where our civilian counterparts sometimes cannot go. They are trained and ready, as other CF members are trained and ready, to respond to our country's demands.

CONTINUITY OF CARE

4.13 Concern over continuity of care, or lack thereof, is the main issue that led the CDS to ask CRS to conduct a *Review of the Medical Services*.

4.14 We all agree, the broken minds and broken bodies that populate the CF require nurturing. Symptoms are complex, treatment regimes comprehensive. For CF members, the ability to establish a strong, stable therapeutic relationship with health care providers is vital. For DND, the responsibility to provide a minimum of 'continuity of care' is fundamental.

4.15 To provide continuity of care, especially in the many under-serviced areas where the CF operate, DND needs to provide a health care structure that offers a minimum of stability, that is accredited, and that is managed with clearly articulated direction and guidance.

4.16 How do we go about establishing a stable health care structure? First, the Task Force undertook to articulate the areas of health care where uniformed health care providers should concentrate their effort. Enclosure 2 summarises the outcome of that work. As you can see, civilian employees or contractual arrangements, especially at home, could take care of approximately 60 per cent of the mandated work. Who does the work right now? Often nobody. This affects all areas of health services delivery, at home and abroad. Civilian resources are required to offset these shortfalls.

4.17 Second, the Task Force undertook to articulate the essential in-garrison health care functions that, if provided in a stable environment by means of a core civilian capability, would have the greatest impact on continuity of care. Forces-wide, Certified Health Service Executives should manage clinics. The intent would be to create a network of Certified Health Service Executives to enhance accessibility, both locally and trans-regionally. In addition, there should be a number of civilian general practitioners, nurse practitioners, and/or care managers, at each site for the larger sites or in every region, to cater to those individuals who require more nurturing by virtue of the complexity of their medical conditions. Finally, core civilian

personnel should perform the reception, appointment, medical records and patient tracking functions. Civilian resources, the number of which will be site specific, are required to offset current shortfalls and ensure continuity. Additionally, this presupposes the existence of hiring mechanisms that facilitate and support the process, and that ideally, would not see us competing against provinces for scarce health professionals.

4.18 Third, the Task Force tackled the standard of in-garrison health care. Evidence presented to the team indicates that the standard of in-garrison health care needs serious improvement. To address this concern, the team resolved to establish partnerships with the Canadian College of Health Service Executives and with the Canadian Council on Health Services Accreditation. The latter organisation surveys establishments and declares them 'Accredited' providing they meet a set of standards. The idea would be to confirm the standards, survey all sites to determine the capability gap and resource it, thus restoring the standard of in-garrison health care. We have yet to determine what resources will be required to offset these shortfalls.

4.19 Fourth, the Task Force considered other ways to enhance accessibility and relieve shortages such as the Designated Provider Plan. With the advent of the DNC/VAC MOU on 1 April 2000, the Designated Provider Plan will open up a network of caregivers to care for the health care needs of CF members. This will provide some relief, however, it will be of little help to those located in under-serviced areas.

4.20 Reservists are a primary pool of resources from which to draw to enhance accessibility and relieve shortages. Health care professionals, who join the Medical Reserve, hold the same licenses and train to the same standards as their Regular Force colleagues. In addition, they are networked or employed, often full-time, in the civilian health care sector. Significant benefits would accrue from the amalgamation of Reserve and Regular Force health care personnel into a unified military component of the total health care team.

4.21 Fifth, the Task Force considered the requirement for maintenance of clinical competence of health care providers. As indicated previously, the gap between the civilian and military health care capabilities is widening rapidly. The solution is to secure maintenance of clinical competence opportunities in the civilian community for uniformed health care providers. In partnership with the Canadian College of Health Service Executives, it is proposed to enlist the support of some of the largest Canadian health care organisations to secure maintenance of clinical competence opportunities. To this end, we must move forward with the licensing of medical/physician assistants or with the development of a licensed alternative to this occupation. In addition, we must also find a way to deal with provincial-licensing barriers – another impediment we will have to overcome.

4.22 Finally, the Task Force considered the complexity of current command and control relationships and its impact on existing departmental vertical and horizontal accountability structures. It surmised that there is a need to centralise the capacity to command and control health care resources and develop the required accountability framework.

4.23 Health care concerns touch everyone, irrespective of service affiliations. Without healthy sailors, soldiers and air personnel, the CF cannot deploy. A corporate account has already been set up to finance the delivery of health services to CF members. Because of his ready access to the full spectrum of uniformed health care expertise, DGHS already does most, if not all of ADM (HR-Mil)'s health policy and managing authority work. The latter will be especially true with the Medical School becoming a unit of DGHS instead of CFRETS. DGHS is the joint force generator of the CF health care capability. He has to be able to support the navy and provide diving medicine support. He has to be able to support the army and provide operational health care support anywhere on the non-linear battlefield. He has to be able to support the air force and provide flight medicine support. Finally, by virtue of his unique role, DGHS has to be able to work at the strategic, operational and tactical levels. DGHS is in a unique position that argues for his becoming a Level One. Designating DGHS as a Level One in the NDHQ hierarchy would send CF members the key message of the importance DND attaches to health care issues.

KEY ENABLERS

4.24 Putting the 'care' back into 'health care' is a massive undertaking on par if not bigger than our Quality of Life initiative. It will take a lot of concerted effort and it will take time. What are the essential enablers to success? First, a Senior Review Board comprised of the CDS/DM and selected DMC members. Second, there is a requirement to create a PMO, with CRS oversight. Third, the Chain of Command must get involved in the design and implementation of command and control arrangements that will enhance the provision of the health care support necessary to sustain a multi-purpose, deployable, combat capable force across the full spectrum of military scenarios. Fourth, there is a need to partner with essential civilian health care organisations such as the Canadian College of Health Service Executives and the Canadian Council on Health Services Accreditation. Finally, there is a need for a strong Communications Approach, which has been developed by DGPA.

COMMITMENT

4.25 In the Task Force's opinion, it is not the work ethic, dedication or professionalism of Medical Branch personnel that resulted in the problems identified by CRS. Before restructuring, uniformed health care providers lacked operational focus, as they were too busy providing in-garrison health care. Post restructuring, uniformed health care providers found that they had fewer resources to provide in-garrison health care; an impossible command structure; a reduced and heavily scrutinised budget; a downsized and restructured civilian health care system, which they had planned to partner with; and sicker people to treat – reflective of the effect of multiple and often stressful deployments.

4.26 The proposed plan provides a well-reasoned strategy for delivery of '*Health Care – One standard, anytime, anywhere*'.

ENCLOSURE 1

CDS TASK FORCE - MEDICAL SUPPORT TO THE CF

Team Leader	-	Col Lise Mathieu, EA/CDS
Participants	-	Col D. Read, SA/VCDS Col D. St-Amour, COS/CFMG Col Quinn, Comd 41 Bde LCol H. Jaeger, CFLSC LCol B. O'Rourke, CFMG LCol M. Roy, CFMG LCol W. Franklin, MARPAC LCol MacGregor, MARLANT Cdr Slaunwhite, HCC CFSU (O) LCdr H. Cunningham. 3 HSOTU Halifax CWO MacBride, MARPAC
Advisors	-	M. Gaston Levac, President Canadian College of Health Service Executives M. Hubley, CRS M. Black, CRS M. McEachern, CRS LCol B. Boudreau, DGPA
Team Support	-	Maj P. O'Grady, CFMG Ms J. Maloney, SO3/CDS

ENCLOSURE 2

PRIORITY OF EFFORT

Operational health care support 1. **Mil** 2. **Civ**

Health Prevention

Preventive Medicine General Hygiene Sanitation Pest Control Public Health/Mandated Programs	 **Civ** **Civ** **Civ** **Civ**	**Collectively – Mil**
Industrial Hygiene In-Garrison Deployed	 **Civ** 1. **Civ** 2. **Mil**	
Operational Medicine Flight Surg/Diving Medicine NBC Policy/Plans	 1. **Mil** 2. **Civ** 1. **Mil** 2. **Civ** **Mil**	
Infectious Disease Control	1. **Mil** 2. **Civ**	
Epidemiology/Disease Tracking	**Civ**	
Medical Intelligence	1. **Mil** 2. **Civ**	
Regulatory Affairs	**Civ**	
R & D	**Civ**	
Human Factors/Ergonomics	**Civ**	
PHE/Medical Category/Screening	1. **Mil** 2. **Civ**	
Immunization Policy R & D Delivery Program administration (records, etc.)	 1. **Mil** 2. **Civ** **Civ** **Civ** **Civ**	

Treatment 1. **Civ** 2. **Mil**

4. Health Promotion **Civ**

BENCHMARKING of MILITARY MEDICAL SYSTEMS

Issues	Canadian Forces Medical System	NZDF Health Services	Defence Medical Service UK MoD	US DoD Medical Services
Retention rates for medical officers	80% attrition rate of GDMOs on completion of obligatory service	Medical Officer cadets generally leave the NZDF upon completion of obligatory service. Specialist Medical Officers are hired for specific contract periods.		11% annual attrition rate of Health Care Officers 40% attrition rate after obligatory service which is 1½ years service for each year of medical training Trend has been improved availability of medical officers as military seen as an attractive alternative to the 'managed health care system' and availability of reserve MOs on longer term contracts
Provision of 'peace-time' in garrison medical care	In-garrison care receives equal priority to operational medicine and training for operations Base Commanders have line responsibility for providing in-garrison care, funded by the CO CFMG. DGHS has functional responsibility for the standard and quality of care provided. Medical resources are mainly civilian physicians coordinated by a HCC and augmented by military medical staff as available. The Designated Provider Plan will increase use and integration with the civilian medical sector for this care	One integrated medical service is provided that includes operational and non-operational medical support. It is a primary health service, with referral and patient management into the NZ public/private health service for secondary health care and above. Operational health service is in uniform and able to deploy. Non-operational health service is both military and civilian.	Under recent restructuring, medical services in-garrison have been shifted to civilian hospitals. Through an agreement with Britain's National Health Service, the MoD has created Ministry of Defence Health Units (MDHUs) in approx 12 civilian hospitals. Military medical personnel staff these units. Spare capacity is shared with the National Health Service.	DoD operates one of the nation's largest health care system. 8.3 million individuals are eligible to receive care through the Military Health Services System (MHSS). To respond to the challenge of maintaining medical combat readiness while providing the best health care for all eligible personnel, DoD has introduced TRICARE, a managed health care program for active duty and retired members of the uniformed service and their families. TRICARE brings together health care resources of the Army, Navy and AirForce and supplements them with networks of civilian health care professionals to ensure access and quality service while

				maintaining the capability to support military operations. All active duty members are enrolled in TRICARE Prime that guarantees access to care in a timely manner at military treatment facilities or through the civilian provider network. All members are assigned a Primary Care Manager who is a health care professional or medical team who patients see first for their health care needs. Primary care managers are supported by military and civilian medical specialists to whom patients are referred if they need special care. DoD healthcare costs per capita are $1807 (US)

Continuity of Care	CF member has a choice of MO where practical as provided by policy The DPP will allow the CF member more consistent access to a continuous care provider Greater reliance on civilian physicians and the public sector health care system encourages continuity of treatment for a specific medical issue. Considerable reliance is placed on the completeness and availability of medical records	Continuity of care is increasingly being provided through civilianization of medical treatment centre personnel, providing greater staff stability and ensuring comprehensive clinical notes. Health services administration ensures that clinical notes are complete, readily available and accounted for. Posting of personnel to one location is for longer durations.	The Defence Medical Service is implementing a cross-service medical information system including a central database of medical information and medical categories. Interfaces enable medical staff to update medical information on service members. The medical supply system will use the data system to improve its distribution, and the defence Epidemiology Agency will use database information in studies of health issues within the military community.	The TRICARE program assigns a Primary Care Manager for each member who is the single opoint of contact for non-emergency health care. Members may select a Primary Care Manager at a military hospital or clinic, or a civilian professional who is a member of the contracted TRICARE network in the community. Primary Care Managers will provide and coordinate care, maintain health records and recommend preventative and wellness services. The PCM will arrange for specialists or hospital admissions when necessary.
Administration of temporary medical categories	Medical categories are assigned when a medical condition imposes limitations to the member from performing his CF duties. Medical categories are to protect the individual from further injury while recovering and ensure the operational effectiveness of the military team. Two medical categories of six months can be assigned locally before a review at HQ for further action. Lengthy delays in assigning and reviewing categories impacts manpower availability	The NZDF Health Service is primarily an occupational health service.Those that do not meet medical standards through injury, illness or tri-annual medicals are restricted through medical grading. Downgraded personnel are managed on a case-by case basis and regularly reviewed. If the condition is long term, consideration is given to serving with limitations or being medically released, usually at the option of the individual.		Members may be placed on limited duty status for 6 to 12 months with restrictions placed on their duties. They are placed in a 'limited duty company' where they are closely monitored and progress towards recovery is monitored. After 12 months, their career status is reviewed. A large component of those on limited duty status are patients with socio/psychological ailments.
Relationship between in-garrison and 'operational' medical care	Ratio of CFMG staff to total is 917/2071 As of 1998, in-garrison health care has been accorded equal priority to operational medical care and training	It is accepted that the NZDF Health Service is an occupational health service to maintain and ensure personnel are fit for service and therefore ther is no 'non-operational' health service. Based on		The medical mission of DoD is to provide medical services and support to the armed forces during military operations and to provide medical services and support to the

	for operational deployment.	capital costs, personnel and operating costs, 48% is attributed to operational and 52% to non-operational health costs.		members, families and others entitled to military medical care. Preparedness to provide needed support is an integral part of the department's mission. The TRICARE system which includes supplementing military treatment facilities with resources and health care professionals from civilian medical organizations permits a high rate of medical unit readiness to support military forces Availability of reserve medical officers for deployment or backfill domestic positions facilitates medical support for military operations.
Maintenance of medical competency	Achieved through embedding in civilian sector facilities, CME, conferences and military medical specialty courses MOCOMP training for specialists and nursing staff LPN and EMT training to be provided to Med As	A priority of the NZDF. Surgeons and anaesthetists are on contract for 1 – 3 years ensuring they are clinically current and available for deployment. Medical officers have 22 working days clinic leave per year, augmented by conferences, seminars and courses.	The creation of the MDHUs is intended to provide military doctors greater exposure to a wide range of medical cases including trauma and other specialties. Medical staff drawn from these facilities are expected to have a greater level of experience in cases common to operational theatres.	DoD utilizes the Uniformed Services University of Health Services (Betesda Md.) to train medical officers at a cost 300% greater than a civilian university. High priority is given to GME (Graduate Medical Education) as well as providing service to a broad spectrum of patients other than active duty members. Ratio of 4:1 of non-members to active duty personnel Trauma skills are maintained through partnering with community general hospitals Reengineering efforts in the AF stipulate number of hours/yr an MO will receive in each area of specialty

Satisfaction of military member with their medical service	Focus group feedback for this review indicates a 44% level of personal satisfaction with treatment received from the CFMS and a 70% satisfaction level with the CFMS as a provider of medical care. QOL issues presented in SCONDVA hearings indicate that a level of dissatisfaction and concern exists regarding services received from the CFMS	Anecdotal evidence indicates general acceptance of the standard of the NZDF medical services. Medical care is an organizational priority as it directly reflects Force morale. Some attitudes reflect unrealistic expectations of full medical care without consideration of resource priorities and medical decisions based on health needs not wants. The NZDF does not provide full medical care, but comprehensive medical care to its armed forces.		1997 surveys of 'managed care' (TRICARE) reflects 16% are dissatisfied with access to healthcare but high levels of satisfaction with quality of care. Introduction of TRICARE has established strict access standards to care and wait times for appointments and diagnostic tests and exams. These standards are not consistently met.
Strategies to strengthen the delivery of medical care to military members	Competitive salaries for medical professionals intended to address MOs concerns Implementation of the DPP will facilitate access to the civilian sector and improve continuity of care in-garrison.	The NZDF has conducted a Defence Medical review focussing on desired outcomes and essential outputs. The purpose is to allow clear delineation of resources and evaluation of outsourcing opportunities where they are cost effective.	MDHUs are intended to improve the availability and quality of medical care for military patients by ensuring a consistent level of service to all members. The facilities are intended to ensure that service medical staff receive adequate training and practice in their specialty areas. The Surgeon General's Information Technology system is intended to strengthen delivery of medical care to service members by providing greater consistency of care than would be available to a less transient civilian population.	The demand for health care has begun to exceed the systems capacity to deliver it – along with the rising cost of health care and the requirement to maintain a trained and ready medical corps to support troops in peace or combat. The TRICARE system has been introduced to meet the challenge of maintaining medical combat readiness and providing quality health care for eligible personnel. On 7 June 99, the White House directed the DoD to introduce steps to implement a combat stress control program and an initiative to expand the community approach to a suicide prevention program

1998/99 CFMS Medical Resources

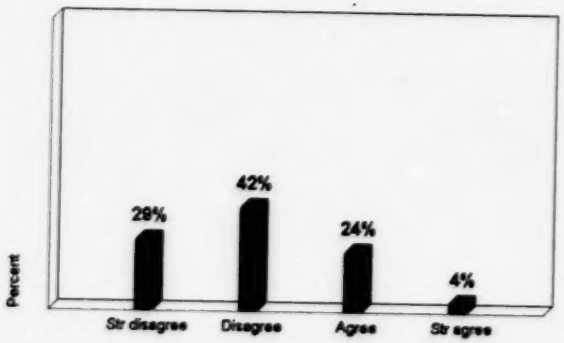
MOC	MOC Occupation	PML Number
58	Social Workers	33
57	Nursing Officers	232
56	Bio-Science Officers	18
55	Medical Officers	212
54	Pharmacists	44
52	Health Service Operation Officers	55
49	Physiotherapists	10
48	Health Care Administrators	123
711	Medical Assistants	1113
713	Operating Room Technicians	29
714	Medical Laboratory Technicians	26
715	X-Ray Technicians	26
716	Preventative Medicine Technicians	76
718	Bio-Medical Medicine Technicians	18
719	Health Services Technician Managers	36
731	Aeromedical Technicians	20
	TOTAL	**2071**

The level of medical care to which CF members are entitled is sufficiently clear and unambiguous.

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree.

Please indicate your level of agreement with this statement

A- The level of medical care to which CF members are entitled is sufficiently clear and unambiguous.

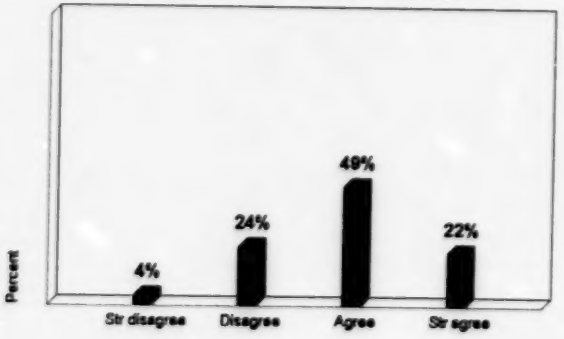


It is necessary to influence CF medical practitioners in matters related to patient care in order to meet the operational needs of the CF.

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree.

Please indicate your level of agreement with this statement

B- It is necessary to influence CF medical practitioners in matters related to patient care in order to meet the operational needs of the CF.

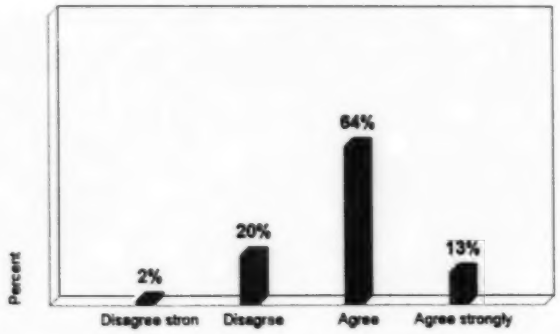


The recommendations for assigning TMC's are respected by the Chain of Command.

1. Disagree strongly
2. Disagree
3. Agree
4. Agree strongly

What is your level of agreement with this statement?

D- The recommendations for assigning TMC's are respected by the Chain of Command.

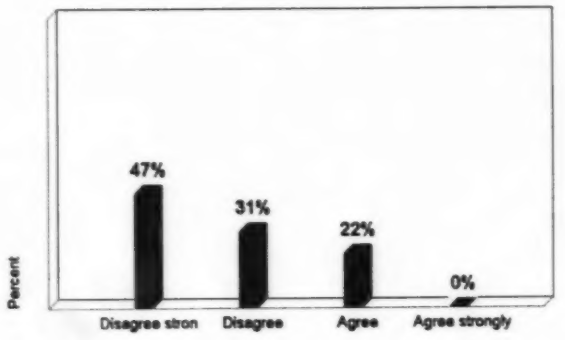


The administrative process of temporary medical categories generally works very well.

1. Disagree strongly
2. Disagree
3. Agree
4. Agree strongly

What is your level of agreement with this statement?

A- The administrative process of temporary medical categories generally works very well.

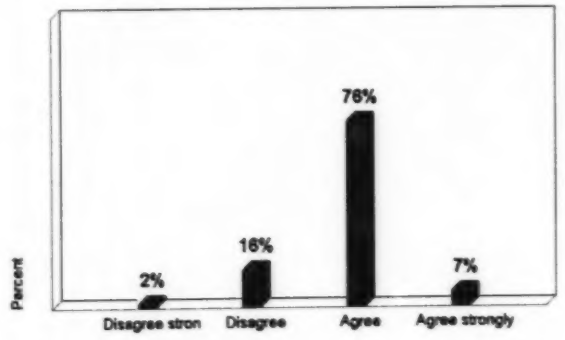


Members on TMC are sometimes viewed as abusing the system and may becorne ostracized by their units.

1. Disagree strongly
2. Disagree
3. Agree
4. Agree strongly

What is your level of agreement with this statement?

B- Members on TMC are sometimes viewed as abusing the system and may become ostracized by their units.

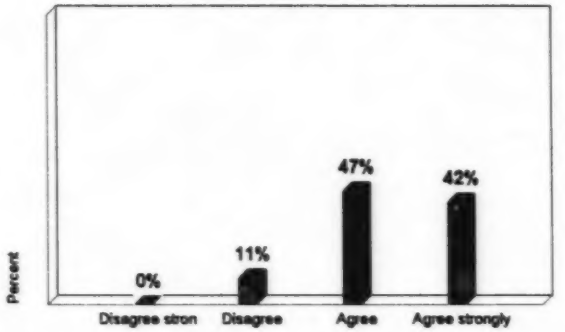


The Chain of Command should play a larger role in monitoring and managing the people who are assigned TMCs.

1. Disagree strongly
2. Disagree
3. Agree
4. Agree strongly

What is your level of agreement with this statement?

C- The Chain of Command should play a larger role in monitoring and managing the people who are assigned TMCs.

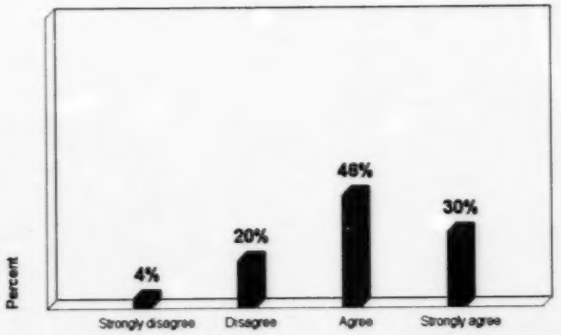


The 'continuity of care' as provided by the CFMS affects the operational capability of the CF:

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

What is your level of agreement with this statement?

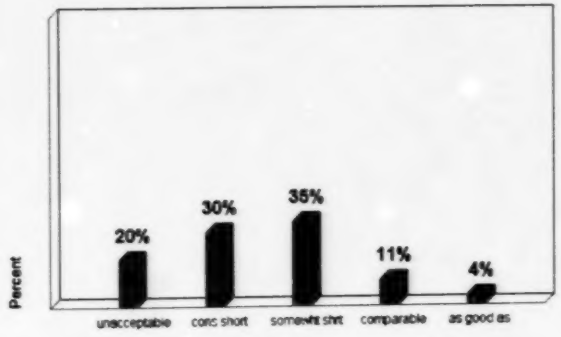
G- The 'continuity of care' as provided by the CFMS affects the operational capability of the CF:



Continuity of care in the CF:

1. Is unacceptably poor for CF members.
2. Falls considerably short of that which is available in the civilian sector.
3. Falls somewhat short of that which is available in the civilian sector.
4. Is comparable to that which is available in the civilian sector.
5. Is as good as it can be given the highly mobile nature of medical service providers and patients in the CF.

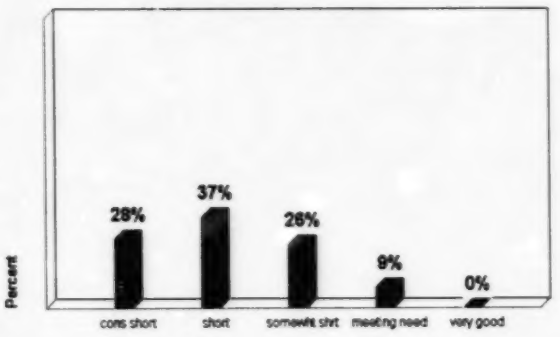
H- Continuity of care in the CF:



I would describe the administration related to the delivery of medical services as:

1. Falling considerably short of meeting the needs of CF members to the extent that it is burdensome for patients.
2. Falling short of meeting the needs of CF members.
3. Falling somewhat short of the needs of CF members.
4. Good at meeting the needs of CF members.
5. Very good at meeting the needs of CF members.

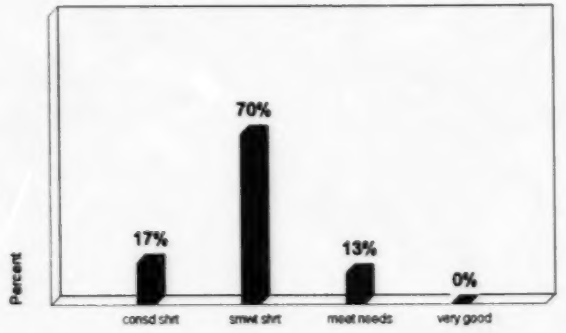
D- I would describe the administration related to the delivery of medical services as:



I would describe the level of concern that the CF has for meeting the medical needs of its members as:

1. Falling considerably short of meeting the needs of CF members.
2. Falling somewhat short of the needs of CF members.
3. Good at meeting the needs of CF members.
4. Very good at meeting the needs of CF members.

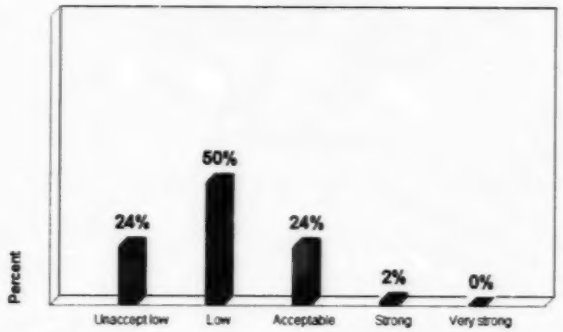
E- I would describe the level of concern that the CF has for meeting the medical needs of its members as:



I would describe the level of effort that the CF invests in order to meet the health care needs of CF members as:

1. Unacceptably low
2. Low
3. An acceptable level of effort
4. Strong
5. Very strong

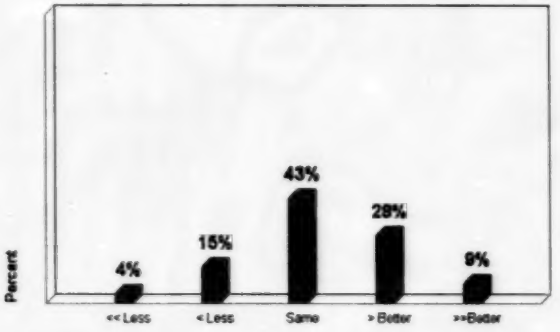
F- I would describe the level of effort that the CF invests in order to meet the health care needs of CF members as:



The level of medical care provided to CF members compared to provincial coverage provided to other Canadians is:

1. Much less
2. Less
3. About the same
4. Better
5. Much better

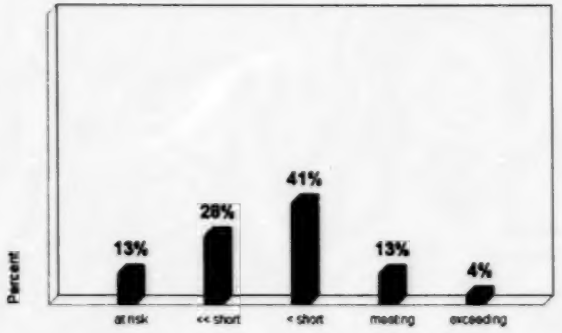
A- The level of medical care provided to CF members compared to provincial coverage provided to other Canadians is:



I would describe the standard of medical care being received by CF members as:

1. Falling considerably short of meeting the needs of CF members to the extent that patients are at risk.
2. Falling short of meeting the needs of CF members.
3. Falling somewhat short of the needs of CF members.
4. Meeting the needs of CF members.
5. Exceeding the needs of CF members.

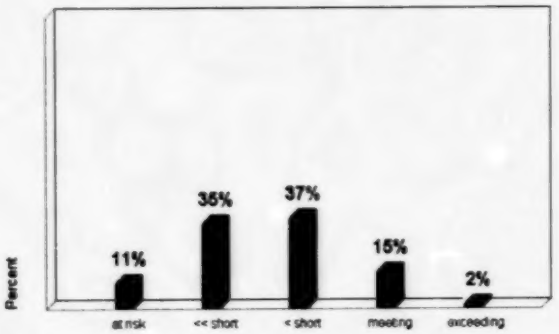
B- I would describe the standard of medical care being received by CF members as:



I would describe the timeliness of delivery of medical services as:

1. Falling considerably short of meeting the needs of CF members to the extent that patients are at risk.
2. Falling short of meeting the needs of CF members.
3. Falling somewhat short of the needs of CF members.
4. Meeting the needs of CF members.
5. Exceeding the needs of CF members.

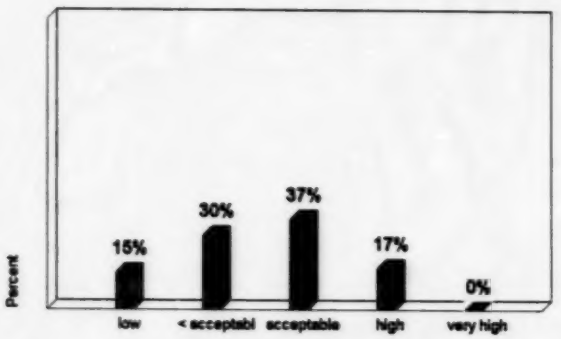
C- I would describe the timeliness of delivery of medical services as:



My level of confidence in the CFMS' ability to deliver medical care in support of CF operations is:

1. low
2. less than acceptable
3. acceptable
4. high
5. very high

D- My level of confidence in the CFMS' ability to deliver medical care in support of CF operations is:



My level of confidence in the CFMS' ability to deliver quality patient care to CF members is:

1. low
2. less than acceptable
3. acceptable
4. high

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